

# Chiropractic Case History Form

Date	Time
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Dear Patient, Welcome to La Vista Chiropractic & Wellness Center! We look forward to working with you to achieve optimum health for your family. Research shows that if uncorrected, many spinal/nervous system problems can become the more complicated problems that become more debilitating and prevent you from living the life you are wanting. To help us serve you better, please complete the following information.

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## Personal Information

Name: \_\_\_\_\_  
 (Legal First) Middle Initial (Legal Last)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Age: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender (circle): M F  
 DOB

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Type of Work: \_\_\_\_\_ (i.e. professional, secretarial, tradesperson, laborer, homemaker, student, retired)

Health Insurance Company name (if applicable): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's SSN#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

How did you hear about our office? Is there someone that we may thank for referring you to our office?  
 \_\_\_\_\_

## Past Health Information

### FAMILY DOCTOR'S NAME AND INFORMATION

Dr.'s Name \_\_\_\_\_ Clinic Name/Location \_\_\_\_\_ Date of Last Physical \_\_\_\_ / \_\_\_\_ / \_\_\_\_

MAJOR SURGERY/OPERATIONS: APPENDECTOMY/TONSILLECTOMY/GALL BLADDER/HERNIA  
 BACK SURGERY/NECK SURGERY/BROKEN BONES/OTHER: \_\_\_\_\_

### HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? ( ) No ( ) Yes (please provide info)

Dr.'s Name \_\_\_\_\_ Clinic Name/Location \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

### MAJOR ACCIDENTS OR FALLS CONTRIBUTING TO CURRENT PROBLEM:

Approximate Date: \_\_\_\_\_ Describe Incident: \_\_\_\_\_

MRI STUDIES FOR CURRENT PROBLEM? NO YES  
 IF YES, DATE AND HOSPITAL OR FACILITY \_\_\_\_\_  
 ANY KNOWN ALLERGIES? \_\_\_\_\_

Supplement/Medication Name	Amount Taken (mg)	How long I've been taking it	Reason for Supplement/Medication

### Adult- (18 to present)

### Rate the following as Poor, Good, Excellent

Do/did you smoke?	Yes	No	Diet:	Poor	Good	Excellent
Do/did you drink alcohol?	Yes	No	Exercise:	Poor	Good	Excellent
Do/Did you play adult sports?	Yes	No	Sleep:	Poor	Good	Excellent

On a scale of 1-10 describe your stress level: (1 = none/ 10 = extreme) Occupational \_\_\_\_\_ Personal \_\_\_\_\_

Please check (O) all symptoms you have ever had, even if they do not seem related to your current problem(s):

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs     | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck Pain                |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell                | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Loss of balance          |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears              | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness              |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes             | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach Upset            |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension                  |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Stiff Neck                   | <input type="checkbox"/> Cold Hands             | <input type="checkbox"/> Cold Feet                |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot Flashes              |
| <input type="checkbox"/> Cold Sweats              | <input type="checkbox"/> Lights bother eyes           | <input type="checkbox"/> Urinary Problem        | <input type="checkbox"/> Heartburn                |
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> Menstrual Pain               | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Seasonal Allergies       | <input type="checkbox"/> Loss of Appetite             | <input type="checkbox"/> Excessive Thirst       | <input type="checkbox"/> Gas/Bloating after meals |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Blood pressure problem | <input type="checkbox"/> Irregular heartbeat      |
| <input type="checkbox"/> Ankle swelling           | <input type="checkbox"/> Prostrate/sexual dysfunction | <input type="checkbox"/> Dental problems        | <input type="checkbox"/> Sinusitis                |

FEMALES ONLY: When was your last period? \_\_\_\_\_ Are you or is there a possibility that you are pregnant? Y N

Childhood History: Circle all that apply

- |  |     |    |  |     |    |           |
|--|-----|----|--|-----|----|-----------|
| Did you have any childhood illnesses?                    | Yes | No | Drink 8-10 cups of water daily?            | Yes | No | Sometimes |
| Did you have any serious falls as a child?               | Yes | No | Use Vitamins or supplements?               | Yes | No |           |
| Did you play youth sports?                               | Yes | No | Drink Soda                                 | Yes | No |           |
| Did you take medications?                                | Yes | No | Belong to a Health Club/Gym                | Yes | No |           |
| Have you fallen/jumped from a height over three feet?    | Yes | No | Watch more than 5 hours of TV per week?    |     |    |           |
| Were you in any car accidents as a child?                | Yes | No |  | Yes | No |           |
| Did you suffer any other traumas (physical or emotional) | Yes | No | Spend 1 or more hours on a computer daily? |     |    |           |
| As a child, were you under regular chiropractic care?    | Yes | No |  | Yes | No |           |

Please mark an "X" where you believe your health is and an "O" where you would like it to be between the lines.

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0	Very Challenged	Challenged	Transition	Good	Excellent	100
	0-59%	60-69%	70-79%	80-89%	90-100%	

**Patient Informed Consent and Financial Policy:**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that La Vista Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and any amount authorized to be paid directly to La Vista Chiropractic will be credited to my account. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I further understand that if payment is not collected in a timely manner I may be subject to collections means and/or interest payments of 14%.

**Medicare/Medicaid Patient Certification and Payment Request:** I certify that the information given by me in applying for the payment under Title XIX and/or Title XI of the SSA, is correct.

**Assignment of Benefits:** I hereby assign payment directly to the physician accepting the assignment of medical benefits to my health insurance applicable and otherwise payable to me but not to exceed the physician's regular charges. If my care is the result of an auto accident, I authorize the benefits of my auto insurance medical payment's policy to be made directly to La Vista Chiropractic for services related to that auto accident and the remaining balance, if any/ may be submitted to my health insurance coverage. I understand and agree that La Vista Chiropractic will as a policy bill the auto insurance directly for my expenses and my health insurance will be considered only as a last resort for payment.

**Informed Consent for Treatment:** I voluntarily consent to the rendering of care, including examination, treatment and diagnostic testing as ordered by the staff physician. I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I understand that ultimately it is my decision to proceed with any instructions given by my physician.

As with any healthcare problem, there are certain complications that may arise during chiropractic adjustments and therapy. Soreness as in that experienced following exercise is common. Dizziness, fractures/joint injury may occur but are relatively rare. Nerve damage or stroke is reported to occur once in one million to once in ten million adjustments. This is comparable to your chance of getting hit by lightning. Your chiropractor will make every reasonable effort to screen for complications of care; but if you have a condition that would not otherwise come to my attention, it is your responsibility to inform me. Other treatment options may include: self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization and surgery. If you chose one of these options listed you should be aware that there are risks and benefits of such options. The risks and dangers of remaining untreated: Remaining untreated may allow formation of adhesions to reduce mobility which may set up a pain reaction further reducing mobility. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

It is understood that the amount paid for x-rays, is for examination only and the X-ray originals remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Do you have any questions regarding the above authorization statement? ( ) No ( ) Yes, Please explain:

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor/CA Initials \_\_\_\_\_

If you have no symptoms/complaints, and are here for wellness care please check here and skip to the next page.

**Please briefly explain the primary health challenge that brought you into our office today:**

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Please provide the following information if it pertains to you.

**1. Headaches:** YES NO (If no, skip to # 2)

**WHEN THEY STARTED:** # of days ago \_\_\_\_\_ #Weeks ago \_\_\_\_\_ #Months ago \_\_\_\_\_ #Years ago \_\_\_\_\_

**HOW OFTEN THEY OCCUR:** \_\_\_ DAILY \_\_\_ Weekly \_\_\_ Monthly \_\_\_ # per day \_\_\_ # per week \_\_\_ #/month

What accidents/events do you think are the cause? \_\_\_\_\_

What makes it better: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

Where is the pain located? Frontal / Back of head / Behind eyes / Sides of head

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

**2. Neck Pain:** YES NO (If no, skip to # 3)

**WHEN IT STARTED:** # of days ago \_\_\_\_\_ #Weeks ago \_\_\_\_\_ #Months ago \_\_\_\_\_ #Years ago \_\_\_\_\_

**HOW OFTEN IT OCCURS** : \_\_\_ DAILY \_\_\_ Weekly \_\_\_ Monthly \_\_\_ # per day \_\_\_ # per week \_\_\_ #/month

What accidents/events do you think are the cause? \_\_\_\_\_

What makes it better: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Do you experience tingling or numbness in any of the following areas?

Head/Face Lt arm/Lt Hand Rt arm/Rt hand

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

How would you describe the amount of time that you have neck pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

**3. Mid Back Pain:** YES NO (If no, skip to # 4)

**WHEN IT STARTED:** # of days ago \_\_\_\_\_ #Weeks ago \_\_\_\_\_ #Months ago \_\_\_\_\_ #Years ago \_\_\_\_\_

**HOW OFTEN IT OCCURS:** \_\_\_ DAILY \_\_\_ Weekly \_\_\_ Monthly \_\_\_ # per day \_\_\_ # per week \_\_\_ #/month

What accidents/events do you think are the cause? \_\_\_\_\_

What makes it better: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

How would you describe the amount of time that you have mid-back pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

**4. Lower Back Pain:** YES NO (If no, skip to # 5)

**WHEN IT STARTED:** # of days ago \_\_\_\_\_ #Weeks ago \_\_\_\_\_ #Months ago \_\_\_\_\_ #Years ago \_\_\_\_\_

**HOW OFTEN IT OCCURS** : \_\_\_ DAILY \_\_\_ Weekly \_\_\_ Monthly \_\_\_ # per day \_\_\_ # per week \_\_\_ #/month

What accidents/events are the cause \_\_\_\_\_

What makes it better: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

Type of pain: Dull / Sharp / Achy / Shooting / Throbbing

Do you experience tingling or numbness in any of the following areas?

Buttock Lt thigh Rt thigh Lt foot Rt foot

Severity: (circle range) 1 2 3 4 5 6 7 8 9 10 = Emergency room

How would you describe the amount of time that you have lower back pain? (circle one)

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Infrequent (0-25%)

Please circle if you are experiencing any pain or restrictions in the following areas:

KNEE ELBOW WRIST ANKLE RIB/ CHEST HIP SHOULDER

## FUNCTIONAL ASSESSMENT ACTIVITIES OF DAILY LIVING

**Please report any limitations that you are experiencing.** Please note that this form is important as it helps us document Medical Necessity which helps determines whether or not your insurance company is liable for coverage. **DO NOT SKIP OVER THIS SECTION.** Check the best statement that applies:

### 1. Standing

- I can stand as long as I want without pain  
 I can stand about 60 mins without pain  
 I can stand between 45-60 mins without pain  
 I can stand between 20-45 mins without pain  
 I can stand between 5-20 mins without pain  
 I am unable to stand without pain

### 3. Walking

- I can walk as long as desired without pain  
 I can walk one or more miles without pain  
 I can walk ½ miles without pain  
 I can walk 1 block without pain  
 I can walk 50 feet without pain  
 I am unable to walk without pain

### 5. Housework

- I am able to do moderate housework without pain  
 I'm can do 60 min of moderate housework w/out pain  
 I can do 45 mins of moderate housework w/out pain  
 I can do 20 mins of moderate housework w/out pain  
 I can do 5-20mins of moderate housework w/out pain  
 I cannot do moderate housework without pain

### 2. Bending

- I can bend as far as wanted without pain  
 I can bend about 80 degrees without pain  
 I can bend about 60 degrees without pain  
 I can bend about 40 degrees without pain  
 I can bend about 10 degrees without pain  
 I cannot bend without pain

### 4. Sitting

- able to sit with no pain  
 able to sit 6mor more hours without pain  
 able to sit 4 or more hours without pain  
 able to sit 2 or more hours without pain  
 able to sit 1 hour or more without pain  
 I am unable to sit without pain

### 6. Lifting

- I can lift heavy weights without pain  
 I can lift 50 pounds without pain  
 I can lift 30 pounds without pain  
 I can lift 20 pounds without pain  
 I can lift 5-15 pounds without pain  
 I cannot lift without pain

### Patient Consent for Use and Disclosure of Protected Health Information

With my consent, La Vista Chiropractic & Wellness Center, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to La Vista Chiropractic & Wellness Center, PC Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. La Vista Chiropractic & Wellness Center, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to La Vista Chiropractic & Wellness Center, PC. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, the doctors at La Vista Chiropractic & Wellness Center, PC may decline to provide treatment to me.

With my consent, La Vista Chiropractic & Wellness Center, PC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, calls pertaining to my clinical care, including laboratory results among others. Also, with my consent, La Vista Chiropractic & Wellness Center, PC may send mail to my home involving any of the items named in this paragraph pursuant to my clinical care and/or insurance status as long as they are marked personal and confidential.

Please be advised that our treatment area is an open environment. At times, it may be impossible to avoid overhearing all conversations. We respect the right for privacy. Please inform us if you have an issue which needs to be discussed in private.

By signing this form, I am consenting to the use by LaVista Chiropractic & Wellness Center, PC of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

\_\_\_\_\_  
 Printed Name of Patient

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Patient or Legal Guardian