Chiropractic Case History/Patient Information

Dr. Joseph Diana 1056 Grant Street Hazle Township, PA 18202

Date:_____ Office use only: Patient # _____

First Name:_____ Last Name: _____ Middle Initial:_____

Nick Name:_____

Address: _____City:_____ State: _____ Zip code:_____

SS# _____ Male_____ Female_____

Marital Status (circle one) Single Married Widowed Divorced Legally Separated

Spouse's Name_____ Language spoken (yours): _____

Your Race: _____ Ethnicity (Italian,German,etc): _____

Date of Birth: _____

Contact (Phone) Information: Home: _____ Cell: _____ Carrier:_____

Contact preference: Circle one: Home Cell

Fax Number:_____ Email address: _____

Emergency Contact: Name: _____ Phone # _____

How or who referred to our office?_____

Names and Ages of Children:_____

Your Occupation: _____ Employer: _____

Family Medical Doctor:_____ Date of last physical?_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? (circle one:) YES NO

HISTORY OF PRESENT ILLNESS:

Chief Complaint: (Why are you here?)Symptoms:_____

Date symptoms appeared or accident happened: _____Did you have this condition before? YES NO

Is this due to: Auto _____ Work_____ Other_____ Any days lost from work? _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Check any conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Do you have a history of **stroke** or **hypertension**?_____

List any **major illnesses, injuries, falls, or auto accidents?** _____

List any **surgeries and dates**:_____

What **medications or drugs** are you taking?_____

_____

Do you have any **allergies to any medications *or* any allergies** of any kind? (circle one) Yes No

If yes, describe:_____

Have you been treated for **any health condition** by a physician in the last year? Yes No

If yes, describe:_____

Please list **any other health problems you have**, no matter how insignificant they may be:_____
_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____If so, how much per week?_____
Are you a current smoker?_____ If so, packs per day: _____ Former Smoker? _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?_____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:
Father: living _____ deceased_____Cause of death: _____

Mother: living _____deceased _____Cause of death: _____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

FAMILY DISEASES (indicate which family member by entering initials: F, M, S, B, A, U, MGF, MGM, PGF, PGM) **F**ather, **M**other, **S**ister, **B**rother, **A**unt, **U**ncle, **MGF** maternal grandfather, **MGM** maternal grandmother, **PGF** paternal grandfather, **PGM** paternal grandmother):

Tuberculosis_____
Diabetes _____
Stroke _____
Arthritis_____
Other _____

Cancer_____
Asthma_____
Kidney Disease_____
Liver Disease _____

Mental Illness_____
Heart Disease _____
Lung Disease_____

Please circle any and all insurance coverage that may be applicable in this case:
π Group Insurance π BC/BS π Medicaid π Medicare
π Medical Savings Account & Flex Plans π Worker's Compensation π Auto Accident

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____
AUTHORIZATION AND RELEASE: **I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. Finance charges will be applied on all accounts over 30 days.**

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

AUTHORIZATION OF CARE OF A MINOR CHILD (UNDER 18 YEARS OLD)

Parent's Name: _____ Phone/Cell #_____

I herby authorize and consent to the chiropractic evaluation and care of my child

Parent Guardian Signature _____Date:_____

Witness Signature_____Date:_____