Patient Information/Case History

OFFICE USE: Patient #___________
Doctor: ________________________

Name: ____________________________________ Date: _________________

Address: ____ City: _________________ State: ______ Zip: ________

Home Phone: __________________ Cell Phone: _________________ Email: ___________________________________

D.O.B: __________________ Sex: _______ Marital Status: M S W D SSN: __________________________

Occupation: ________________________________ Employer: ____

Work Address: ____ Work Phone: _________________________

Emergency Contact: ____________________________ Relationship: __________________Phone #: ________________

How did you hear about us: ☐ Website ☐ Newspaper ☐ Event ☐ Social Media ☐ Friend/Family ☐ Sign ☐ Mailing

Were you referred to our office? ☐ Yes ☐ No If yes, by whom: _______________________________________

Name of Primary Insurance Company: _______________________ Policy Number:_______________________________

Name of Secondary Insurance Company (if applicable): ____

Will this visit be a: Workers Compensation Claim? ☐ Yes ☐ No Auto Accident Claim? ☐ Yes ☐ No

HIPAA: The patient understands and agrees to allow Coastline Chiropractic and Rehabilitation Center 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. The following person(s) have my permission to receive my personal health information:

Name: _______________________________________ **Name:** ____

AUTHORIZATION & 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 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.

Patient's Signature: ____ Date: _________________

Guardian's Signature Authorizing Care: ____ Date: _________________

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as appears on Medicare Card____Date____/____/____

COASTLINE CHIROPRACTIC
AND REHABILITATION CENTER

Patient Name: ____ Date: ______________________

CONFIDENTIAL HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint/Purpose of Visit: ____

Describe the onset of discomfort: □ Gradual □ Insidious □ Recent □ Spontaneous □ Sudden □ Traumatic □ Unknown

Date of onset: ____________ Was this due to: □ Auto □ Work □ Other ________________________

Describe the intensity of discomfort: □ Mild □ Mild to Moderate □ Moderate □ Moderate to Severe □ Severe

How often do you feel this discomfort? □ Constant □ Frequent □ Intermittent □ On and Off □ Random □ Recurring

How has the complaint changed since the onset? □ Improved □ Stayed the Same □ Worsened

Have you ever had the same or a similar condition? □ Yes □ No If yes, describe: ________________________

____

Days lost from work: ____________________ Date of last physical exam: ________________________

Do you have a history of Stroke or Hypertension? □ Yes □ No If yes, describe: ________________________

Have you had any major Illnesses, Injuries, Falls, Auto Accidents or Surgeries? Women, please include information about childbirth (Include Dates): ____

____

Have you been treated for any health condition(s) by a physician in the last year? □ Yes □ No If yes, describe: _______

____

Are you currently taking any medication? □ Prescription □ Over-the-counter □ Vitamins/Minerals □ None

If yes, please list them here:____

____

Do you have any allergies to medications? □ Yes □ No If yes, describe: ______________________________

How many hours of sleep do you average each night? ____

Woman: Are you pregnant? □ Yes □ No

Have you had or do you now have any of the following symptoms/conditions? Please mark **N = Now** or **P = Previously**

Headaches	________	High Blood Pressure	________	Arthritis	________
Neck Pain	________	Difficulty Urinating	________	Muscle Spasms	________
Stiff Neck	________	Extremity Weakness	________	Fever	________
Back Pain	________	Loss of Balance	________	Sinus Problems	________
Nervousness	________	Fainting	________	Diabetes	________
Tension	________	Loss of Smell	________	G.I. Problems	________
Irritability	________	Loss of Taste	________	Indigestion	________
Chest Pains/Tightness	________	Cold Feet	________	Jt. Pain/Swelling	________
Dizziness	________	Cold Hands	________	Menstrual Problems	________
Shoulder/Arm Pain	________	Constipation	________	Breathing Problems	________
Finger Numbness	________	Diarrhea	________	Fatigue	________
Toe Numbness	________	Frequent Colds	________	Lights Bother Eyes	________

Ringing of Ears	________	Gall Bladder Problems	________	Irregular Heartbeat	________
Broken Bones/Fracture	________	Ulcers	________	Coughing Blood	________
Heart Attack	________	Weight Loss/Gain	________	HIV (AIDS) or Hepatitis	________
Rheumatoid Arthritis	________	Depression	________	Tuberculosis	________
Excessive Bleeding	________	Memory Loss	________	Renal Disease	________
Osteoarthritis	________	Circulation Issues	________	Herpes Simplex Virus	________
Pacemaker	________	Thyroid Disorder	________	Seasonal Allergies	________
Stroke	________	Seizures/Epilepsy	________	Asthma	________
Ruptures	________	Low Blood Pressure	________	Lung Disease	________
Eating Disorders	________	Osteoporosis	________	Cancer	________
Blood Clots	________	Heart Disease	________	Liver Disease	________

SOCIAL HISTORY

Please indicate if any of the following apply to you:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise		Tobacco Use		Financial Pressures	
Moderate Exercise		Caffeine		High Stress Activity	
Alcohol Use		Carbonated Beverages		Other Mental Stresses	
Drug Use		Family Pressures		Other (specify)______________	

Do any of your family members have a history of the following:

Medical Condition	**No**	**Do Not Know**	**Yes**	**Comments: List your relationship of the person with the condition; for example, mother, maternal aunt, paternal grandfather, etc.**
Heart Disease, Heart Attack, Stroke, High Blood Pressure	☐	☐	☐	
Cancer	☐	☐	☐	
Kidney Disease, Liver Disease, Lung Disease	☐	☐	☐	
Scoliosis, Osteoporosis, Bone Defect	☐	☐	☐	
Arthritis, Joint problems	☐	☐	☐	
Epilepsy	☐	☐	☐	
Headaches, Migraines	☐	☐	☐	
Diabetes	☐	☐	☐	

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian ____Date____________

Name: ____ D.O.B: ___/____/____ Date: ____________

Review of Systems

Please check any of the following symptoms you have experienced recently.

SKIN:

□ Rashes

□ Lumps

□ Dry skin

□ Itching skin

□ Easily bruises

□ Color changes

HAIR:

□ Abnormal loss

□ Abnormal growth

NAILS:

□ Color changes

□ Brittle

□ Abnormal growth

HEAD:

□ Headaches

□ Head injury

□ Fainting spells

□ Dizzy spells

□ Seizures

EYES:

□ Pain

□ Eye injury

□ Any visual problems

□ Light sensitive

□ Blurred vision

□ Double vision

□ Excessive tearing

EARS:

□ Earache

□ Itching

□ Ringing

□ Hearing loss

□ Loss of balance

□ Discharges

□ Infections

NOSE AND SINUSES:

□ Pain

□ Bleeding

□ Congestion

□ Broken nose

□ Loss of smell

HEART AND VESSELS:

□ Irregular heart beats

□ Racing heart

□ Difficult breathing with exertion

□ Cold feet and hands

□ Skin color changes

□ Swollen ankles or feet

□ Muscle pains upon walking

□ High blood pressure

MOUTH AND THROAT:

□ Mouth pain

□ Dentures

□ Cavities

□ Throat pain

□ Swollen glands

□ Hoarseness

□ Gagging

□ Choking

□ Bleeding (mouth)

□ Sore throat

□ Clicking jaw

□ Difficulty swallowing

LUNGS:

□ Chest pains

□ Shortness of breath

□ Difficult breathing

□ Breath odors

□ Cough

□ Phlegm

□ Night sweats

□ Chest noises

ABDOMEN

□ Pain

□ Gas

□ Nausea

□ Vomiting

□ Yellowish skin or eyes

□ Appetite problems

□ Constipation

□ Diarrhea

□ Hemorrhoids

GENITAL AND URINARY SYSTEM:

□ Painful urination

□ Difficulty urination

□ Change in frequency of urination

□ Night time urination

□ Blood in urine

□ Bleeding or spotting

□ Prostate problems

□ Venereal disease

MENSTRUAL/OBSTETRICAL (M.O.):

Date of last Gynecological exam____________

Menarche Age______

Last Period Date___________

Length of Period___________

Menopause Age_____

□ Menstrual irregularity

□ Menstrual cramps

□ Spotting between periods

□ Vaginal discharges

□ Vaginal odors

□ Breast swelling

□ Breast infections

□ Breast lumps

□ Breast dimpling

NERVOUS SYSTEM (N.S.):

□ Numbness

□ Tingling

□ Twitching

□ Loss of balance

□ Coordination problems

□ Nervousness

□ Convulsions

□ Memory lapse

□ Mental health conditions

MUSCULOSKELETAL (M.S.):

□ Loss of joint motion

□ Joint noises

□ Joint pain

□ Joint swelling

□ Muscle pains or cramps

□ Muscle weakness

□ Muscle disease

□ Bone disease

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian ____Date____________