COASTLINE CHIROPRACTIC
AND REHABILITATION CENTER

Patient Information/Case History

Name: _____ Date: _____

OFFICE USE: Patient #_____
Doctor: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

D.O.B: _____ Sex: _____ Marital Status: M S W D SSN: _____

Occupation: _____ Employer: _____Work Phone:_____

Work Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____Phone #: _____

How did you hear about us: ☐ Google /Bing /Yahoo ☐ Newspaper ☐ Event ☐ Social Media: Facebook/ Twitter /Instagram ☐ Friend/Family ☐ Sign ☐ Mailing ☐ Networking Event ☐ Website ☐ Other:_____

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

Name of Primary Insurance Company: _____ Policy Number:_____

Name of Insured (Primary): _____ D.O.B:_____

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____/____/____

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Patient Name: _____ Date: _____

CONFIDENTIAL HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint/Purpose of Visit: _____

Describe the onset of discomfort: ☐ Gradual ☐ 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

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)_____	

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Family History: 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	□	□	□	

Review of Systems

Please check any of the following symptoms you have experienced.

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

□ Dizziness

□ Seizures

□ Frequent Colds

□ Fever

EYES:

□ Pain

□ Eye injury

□ Any visual problems

□ Light sensitive

□ Blurred vision

□ Double vision

□ Excessive tearing

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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

□ Coughing blood

□ Cold feet and hands

□ Skin color changes

□ Swollen ankles or feet

□ Muscle pains upon walking

□ High blood pressure

□ Low blood pressure

□ Chest pains/Tightness

□ Fatigue

□ Heart attack; Date: _____

□ Stroke; Date: _____

□ Excessive bleeding

□ Pacemaker

□ Ruptures

□ Blood clots

□ Heart disease

MOUTH AND THROAT:

□ Mouth pain

□ Dentures

□ Cavities

□ Throat pain

□ Swollen glands

□ Hoarseness

□ Gagging

□ Choking

□ Bleeding (mouth)

□ Sore throat

□ Clicking jaw

□ Difficulty swallowing

□ Loss of taste

LUNGS:

□ Chest pains

□ Shortness of breath

□ Difficult breathing

□ Breath odors

□ Cough

□ Phlegm

□ Night sweats

□ Chest noises

□ Allergies

□ Season allergies

□ Asthma

ABDOMEN

□ Pain

□ Gas

□ Nausea

□ Vomiting

□ Yellowish skin or eyes

□ Appetite problems

□ Constipation

□ Diarrhea

□ Hemorrhoids

□ Ulcers

□ Eating Disorders

□ Indigestion

□ G.I. problems

GENITAL AND URINARY SYSTEM:

□ Painful urination

□ Difficulty urination

□ Change in frequency of urination

□ Night time urination

□ Blood in urine

□ Bleeding or spotting

□ Prostate problems

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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

□ Finger/Toe Numbness

□ Tingling

□ Twitching

□ Loss of balance

□ Coordination problems

□ Nervousness

□ Depression

□ Seizure/Epilepsy

□ Convulsions

□ Fainting

□ Memory lapse/Loss

□ Tension/Irritability

□ Mental health conditions

DISEASES

□ Diabetes

□ Rheumatoid Arthritis

□ Osteoarthritis

□ Arthritis

□ Gall Bladder

□ Thyroid

□ Liver

□ Cancer

□ Lung

□ Wt. loss/ Wt. gain

□ Osteoporosis

□ Osteopetrosis

□ HIV/AIDS

□ Hepatitis

□ Tuberculosis

□ Renal Disease

□ Herpes Simplex

MUSCULOSKELETAL (M.S.):

□ Loss of joint motion

□ Joint noises

□ Joint pain

□ Joint swelling

□ Muscle pain/cramps

□ Muscle weakness

□ Muscle disease

□ Bone disease

□ Neck pain

□ Neck stiffness

□ Back pain

□ Shoulder/arm pain

□ Leg/knee pain

□ Extremity weakness

□ Fractures

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

Signature of Patient/Legal Guardian: _____ Date: _____