

**PROACTIVE CHIROPRACTIC, P.C.**  
**CASE HISTORY/PATIENT INFORMATION**

Date \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Race \_\_\_\_\_ Marital: M S W D How many children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

In Case of Emergency contact: \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor \_\_\_\_\_ May we contact  
regarding your current complaint and/or current medical problem? \_\_\_\_ Yes \_\_\_\_ No

With whom may we share your information (spouse, parents, etc.)? \_\_\_\_\_

Date symptoms appeared or accident happened \_\_\_\_\_ Days lost from work \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case.

Major Medical  Worker's Compensation  Medicaid  Medicare  Auto Accident  Other

**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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT PRIVACY:** I understand and agree to allow this chiropractic office to use my Patient Health Information only for the purpose of treatment, payment, healthcare operations, and coordination of care. If I would like to have a more detailed account of ProActive's policies and procedures concerning the privacy of my Patient Health Information, I can read the HIPAA NOTICE that is available at the front desk before signing this consent. I know how my Patient Health Information is going to be used in this office and my rights concerning those records. If there is anyone I do not want to receive my medical records, I will inform this chiropractic office immediately.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

**ProActive Chiropractic, P. C.**

Name \_\_\_\_\_ Date \_\_\_\_\_

1. What is your major symptom and it's location? \_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

|\_\_\_\_\_|

Please place an "X" on the line above to indicate your level of problem.

2. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_

3. How did it originally occur? \_\_\_\_\_

Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_

If yes, when and how? \_\_\_\_\_

4. Is there anything you can do to relieve the problem? Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_

\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_  
\_\_\_\_\_

5. What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_

Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_

6. Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_

Burning \_\_\_ Stabbing \_\_\_ Throbbing \_\_\_ Other \_\_\_\_\_

7. Does the pain radiate outward from a central location? Yes \_\_\_\_\_ No \_\_\_\_\_

8. How frequent is the condition? Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only \_\_\_

How long does it last? All Day \_\_\_\_\_ Few Hours \_\_\_\_\_ Minutes \_\_\_\_\_

9. Are there any other conditions or symptoms that may be related to your major symptom?

Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_

Are there other unrelated health problems? Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_

10. Date of last physical examination \_\_\_\_\_

11. Has a physician treated you for any health condition in the last year? π Yes π No

If yes, describe \_\_\_\_\_

12. Have you had any broken bones? Yes \_\_\_ No \_\_\_. If yes, please list and give dates \_\_\_\_\_  
\_\_\_\_\_

13. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_  
 \_\_\_\_\_
14. To your knowledge, have you had any diseases, major illnesses, cancers, or injuries not indicated on this form either in the past or the present? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain and include dates. \_\_\_\_\_  
 \_\_\_\_\_
15. What surgeries have you had? (Include dates) \_\_\_\_\_  
 \_\_\_\_\_
16. What medications, drugs, vitamins, or supplements are you taking? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
17. How often and what form of exercise do you implement? (If none, indicate so) \_\_\_\_\_  
 \_\_\_\_\_
18. Do you smoke? Yes \_\_\_\_ No \_\_\_\_ If yes, how many packs per day? \_\_\_\_\_
19. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
 Yes \_\_\_\_ No \_\_\_\_ Uncertain \_\_\_\_

**CONSENT TO CHIROPRACTIC SERVICES:** I hereby request to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-rays and/or tests by ProActive Chiropractic and their staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor named above and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

DOCTOR'S COMMENTS: \_\_\_\_\_  
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Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_