Chiropractic Case History/Patient Information

Date_____ Patient #_____

Doctor _____

Name _____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail address: _____ Cell Phone _____

Age____ Male ☐ Female ☐ Birth Date_____ Race_____ Marital: M S W D # children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone_____

Spouse _____ Occupation _____ Employer_____

Name of Nearest Relative_____ Address_____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____

What is the name of the clinic your medical doctor practices? _____

May we contact your medical physician for coordination of care? Yes ☐ No ☐

Reason(s) for this appointment Date Began

_____ _____

_____ _____

Have you ever had the same or a similar condition? Yes ☐ No ☐ If yes, when and describe: _____

_____

Days lost from work _____

What surgeries have you had? (Include dates) _____

_____

Serious illnesses (include dates)_____

_____

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

If yes, describe: _____

_____

What medications or drugs (over the counter or prescribed) are you taking and what are they for?

_____

_____

What Vitamins/Supplements or herbs are you taking and why?_____

_____

What Medications are you allergic to?_____

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

Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident ☐ Other ☐

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any)_____

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NO SYMPTOMS ——————————————————— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem. (use multiple Xs if multiple symptoms and note what each represents

1. Have symptoms worsened recently? Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse ☐
   If changed, in what way? _____
2. How frequent are symptoms? Constant ☐ Daily ☐ Intermittent ☐ Night Only ☐
   How long does it last? All Day ☐ Few Hours ☐ Minutes ☐
3. Describe the pain: Sharp ☐ Dull ☐ Numbness ☐ Tingle ☐ Achy ☐ Burning ☐
   Shooting ☐ Stabbing ☐ Other_____
4. Is there anything you can do to relieve the problem? Yes ☐ No ☐
   If yes, describe: _____
5. What makes the problem worse? Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐
   Twisting ☐ Driving ☐ Other:_____
6. Have you had broken bones? Yes ☐ No ☐ If yes, describe:_____
7. List any accidents you have been in (Auto or Work or Other): _____
   _____
8. To your knowledge, have you or do you have any diseases, major illness, or injuries not indicated on this form, either in the past or the present? Yes ☐ No ☐
   Describe:_____
9. Have you had chiropractic care in the past? Yes☐ No ☐ When?_____ Whom?_____
10. Are there any other conditions or symptoms that may be related to your major symptom, OR you would like to have answers about? _____
11. Are there other unrelated problems? Yes ☐ No ☐ Describe:_____
12. Do you have Tingling (**mark with T**), Numbness (**mark with N**), Coldness (**mark with C**), or Burning (**mark with B**) sensations in the following area:

Shoulders___	Arms___	Elbows___	Forearms___	Hands___	Fingers___
Buttocks___	Thigh___	Knees___	Lower Leg___	Calves___	Feet___
Lower Back___	Toes___	Neck___	Upper Back___	Chest___	Groin___

13. Any questions, concerns, comments that you need answered? _____
    _____
14. Do you consider yourself: ☐ underweight ☐ overweight ☐ just right your weight today _____
15. Have you had an unintentional weight loss or gain of 10lbs or more in the last 3 months? _____
16. Is your job associated with potentially harmful chemicals (e.g., pesticides, solvents, radioactivity) or health and/or life threatening activities (e.g., fireman, etc)? _____
    _____
17. **What are your Health Goals?** _____
    _____
    _____

BRITTON Chiropractic & Rehab Clinic

On the picture to the right: Mark the areas on the pictures where you feel the pain with the appropriate symbol(s) listed below. If you pain/sensation travels a distance, then use an arrow that travels the length and direction of the radiation.

Ache > > >

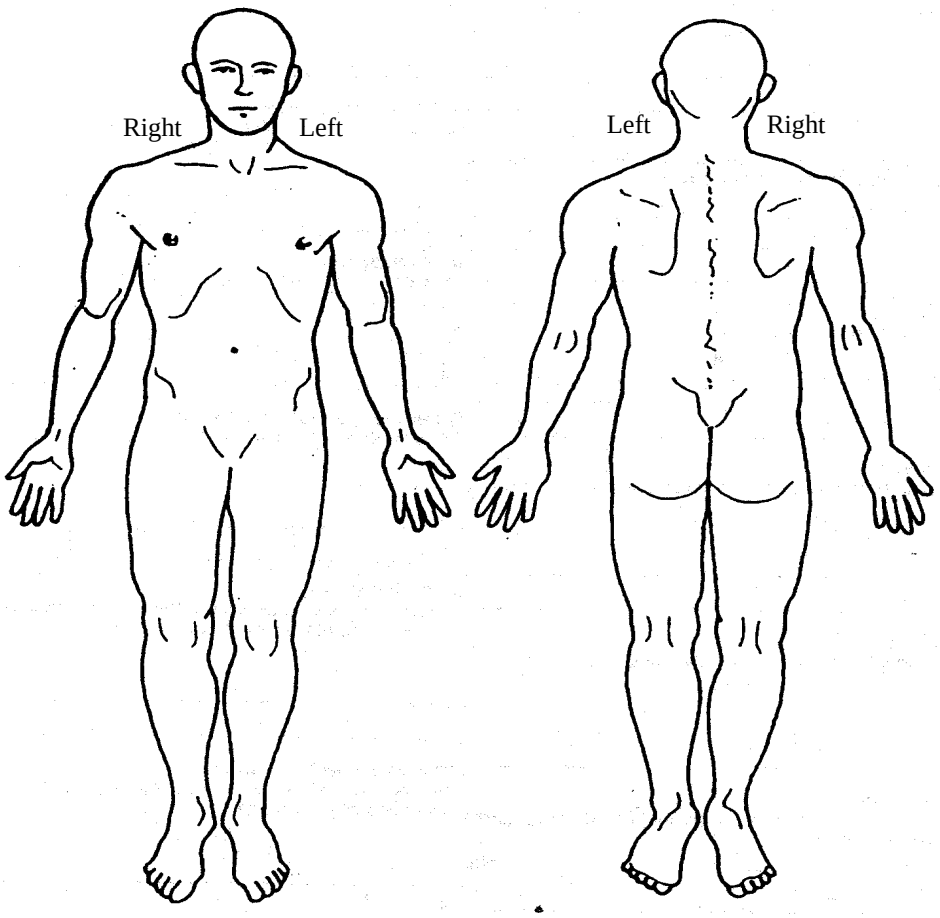
Numbness - - -

Pins/Needles o o o

Burning x x x

Stabbing / / /

Throbbing ~ ~ ~



Medical History

- Anxiety
- Arthritis
- Allergies/Hay Fever
- Asthma
- Alcoholism
- Alzheimer's
- Autoimmune Disease
- Bedwetting
- Blood Pressure
- Bruise Easily
- Bursitis
- Cancer
- Chronic Bronchitis
- Chronic fatigue
- Carpal Tunnel Synd.
- Cholesterol, elevated
  Last test #s: _____
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes (Type 1)
- Diabetes (Type 2)
- Diverticulitis
- Dizziness/Vertigo
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eye/Ear/Nose/Throat Problems
- Environmental sensitivities
- Fibromyalgia
- Food Intolerance
- Gastroesophageal Reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Headache
  - Tension
  - Migraine
  - Cluster
  - Other
- Heart Disease
- Incontinence
- Infection, Chronic
- Inflammatory Bowel
- Irritable Bowel
- Jaw problems
- Kidney/Bladder dis.
  - Infections
  - Stones
- Learning disability
- Liver or Gallbladder
- Lupus
- Mental Illness
- Mental Retardation
- Migraine Headaches
- Neurological prob. (Parkinson's, paralysis etc)
- Sinus problems
- Spinal Surgery
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Plantar Fascitis
- Pneumonia
- Polio
- Psoriasis
- Rheumatism
- Sexually transmitted Disease
- Seasonal Affective Disorder
- Skin Problems
- Tuberculosis
- Ulcer
- Urinary Tract Infect.
- Varicose Veins
- Vision Problems
- Other _____
  _____

Medical (Men)

- Benign Prostatic Hyperplasia (BPH)
- Prostate Cancer
- Decreased Sex Drive
- Other _____
  _____
  _____

Medical (Women)

- Hot Flashes
- Menstrual Irregular
- Endometriosis
- Infertility
- Fibrocystic Breast
- Fibroids/Ovarian Cyst
- PMS
- Breast Cancer
- Pelvic Inflammatory Disease
- Vaginal Infections
- Decreased Sex Drive
- Other _____
  _____

Date of last GYN _____
Mammogram + -
PAP + -
Form of Birth Control
_____
# of pregnancies _____
C-section _____
Age of 1st Period _____
Date start last Menses __
Length of Cycles _____
Days b/t cycles _____
Any recent changes in normal menstrual flow (heavier, large clots, scanty etc) _____
_____

- Surgical Menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's
- Cancer
- Depression

- Diabetes
- Drug Addiction
- Eating Disorder
- Genetic Disorder
- Glaucoma
- Heart Disease
- Infertility
- Learning Disability
- Mental Illness
- Mental Retardation
- Migraine Headaches
- Neurological Disorder (Parkinson's, paralysis etc)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____
  _____
  _____

Health Habits

- Tobacco

Cigarettes/d _____
Cigars/d _____
Cans of Chewing _____

- Alcohol

Wine glass/d or wk _____
Liquor ounces/d or wk ___
Beer glass/d or wk _____

- Caffeine

Coffee 6oz/d or wk _____
Tea 6oz/d or wk _____
Diet Soda can/d or wk ___
Reg. Soda can/d or wk __
Other: _____

- Water 8oz/d or wk __

Exercise

- 5-7 days/wk
- 3-4 days/wk
- 1-2 days/wk
- 45 min or more each
- 30-45 min each
- Less than 30 min
- Walk days/wk _____
- Run/jog/aerobic days/wk _____
- Weight Lift d/wk ____
- Stretch d/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and veg.)
- Vegetarian
- Vegan
- Salt Restriction
- Fat Restriction
- Carb. Restriction
- The Zone Diet
- Calorie Restriction

Specific Food Restrict.
Dairy Wheat Eggs
Soy Corn Gluten
Other _____

Food Frequency

# of servings/day:
Fruits _____
Dark green or deep yellow/orange veg. _____
Grains (unprocessed) ___
Beans, peas, legumes ___
Dairy, eggs _____
Meat, Poultry, Fish ____

Eating Habits

- Skip Meals – which ones: _____
- 1 meal/day
- 2 meals/day
- 3 meals/day
- Graze small/frequent
- Usually eat & run
- Eat constantly if hungry or not

Current Supplements

- Multivitamin/min.
- Vit. C
- Vit. E
- EPA/DHA
- Evening Primrose/GLA
- Calcium (source ____
- Magnesium
- Zinc
- Minerals, describe: _____
- Probiotics
- Digestive Enzymes
- Amino Acids
- CoQ10
- Antioxidants: _____
- Herbs: _____ _____
- Homeopathy: _____ _____
- Protein Shakes
- Superfoods: _____ _____
- Liquid Meals
- Other: _____ _____

I would like to:

ENERGY/VITALITY

- Feel more vital
- Have more Energy
- More Endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds/flu
- Get rid of allergies
- Not be dependent on over the counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids etc
- Stop using laxatives/softeners
- Improve Sex Drive

BODY COMPOSITION

- Lose Weight
- Burn more body fat
- Be stronger
- Better muscle tone
- Be more flexible

STRESS/MENTAL

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Less depressed
- Less moody
- Less indecisive
- More motivated

LIFE ENRICHMENT

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a 'treating-illness' orientation to creating a wellness lifestyle.

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 payers 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% after 60 days.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PHI 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 PHI 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 _____

Doctor's Signature _____ Date _____

Dr. Bradley Britton
351 Highway 12
Akron, IA 51001
Ph: 712-568-2304
Fax: 712-568-3792

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Cell #_____

Email_____

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____
Patient Signature Date