Community Chiropractic
Consultation Questionnaire

PATIENT NAME ____

DATE __________________ Dr. Vicki Crum

Please answer questions below in detail. Please circle where appropriate.

1. What is your major symptom? ____

____

2. What does this prevent you from doing or enjoying?_______________________________________

3. If this is a recurrence, when was the first time you noticed this problem?____________________

How did it originally occur?____

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

If yes, when and how? ____

4. How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All Day Few Hours Minutes

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

Yes No If yes, describe: ____

Are there other current health problems? Yes No If yes, describe __________________

____

6. Please rate your pain on a scale of 1-10, with 10 being the worst: _________________________

7. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

Other ____

8. 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? ______________

____

9. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting

Other ____

10. List any major accidents you have had other than those that might be mentioned above:

____

11. Other Remarks:____

____

____

Community Chiropractic
7651 E US Hwy 36
Avon, IN 46123
(317) 272-7988

Chiropractic Case History/Patient Information

Date:__________________ **Doctor: ◯ Vicki Crum, DC**

Name:__________________________ Social Security #__________________ Home Phone: ____________________

Address:____City:___________________ State:______ Zip:___________

E-mail address:____________________________ Cell Phone:__________________ Cell Carrier: ___________________

Age:_______ Birth Date:___________ Marital Status: M S W D Preferred Contact Number (circle) : Home Cell

Occupation:_________________________ Employer:____

Employer's Address:__________________________________ Office Phone:_____________________________

Spouse:___________________ Occupation:________________ Employer:_______________________________

How many children?____________Names and Ages of Children:____

____

Who can we contact in case of an emergency? ____________________________ Phone:___________________

How were you referred to our office?____

Family Medical Doctor:____

OB/GYN (if applicable):____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?___________

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

[ ]Major Medical [ ] Worker's Compensation [ ] Medicaid [ ] Medicare [ ]Auto Accident
[ ] Medical Savings Account & Flex Plans [ ] Other

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 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.

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 (other than the parties mentioned above) that you do want to receive your medical records, please inform our office.

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:______________________________________ Date:________________

Community Chiropractic

PATIENT NAME ____

DATE ____________________ Doctor: Vicki Crum, DC

HISTORY OF PRESENT AND PAST ILLNESS:

Have you ever had the same or a similar condition for which you are presenting? [ ] Yes [ ] No

If yes, when and describe:____

Days lost from work:_________________ Date of last physical examination:_________________________

Do you have a history of stroke or hypertension?____

List dates of any **major** illnesses, injuries, broken bones, auto accidents or surgeries. Women, please include information about childbirth: ____

____

____

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

If yes, describe:____

What medications and/or supplements are you taking?____

____

____

Do you have any allergies to any medications? [ ] Yes [ ] No

If yes, describe:____

Do you have any allergies of any kind? [ ] Yes [ ] No

If yes, describe:____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe ______________________________

Do you have (or had within the last 3 months) any of the following symptoms/conditions? Please place a check next to the condition.

Condition		Condition	
Headaches______ Frequency	________	Loss of Balance	__________
Neck Pain	________	Fainting	__________
Stiff Neck	________	Unusual Bowel Patterns	__________
Nervousness	________	Feet /Hands Cold	__________
Chest Pains/Tightness	________	Dizziness	__________
Shoulder/Neck/Arm Pain	________	Numbness in Fingers/Toes	__________
Diabetes	________	High/Low Blood Pressure	__________
Indigestion Problems	________	Joint Pain/Swelling	__________
Weakness in Extremities	________	Menstrual Difficulties	__________
Breathing Problems	________	Weight Loss/Gain	__________
Fatigue	________	Depression	__________
Lights Bother Eyes	________	Loss of Memory	__________
Ears Ring	________	Broken Bones/Fractures	__________
Circulation Problems	________	Rheumatoid Arthritis	__________
Seizures/Epilepsy	________	Osteoarthritis	__________
Osteoporosis	________	Pacemaker	__________
Heart Disease	________	Stroke	__________
Cancer	________	Gallbladder issues	__________

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SOCIAL HISTORY

Please indicate beside each activity if you engage in it with a **YES**

__________ Exercise ; If so, How Often? __________________ __________ Family Pressures

__________ Financial Pressures __________ High Stress Job __________ Other Mental Stresses

__________ Alcohol Use (How often?__________________) __________ Previous/Current (Circle one) Drug Use

__________ Tobacco Use (How much/often?______________) _________ Other (specify)____________

__________ Caffeine (How much daily?________________)

Have you received chiropractic care previously? ________________________

If so, where?__________________________ Name of Doctor:____________________________________

Describe your experience: ____

____

____

____

FAMILY HISTORY: Please check the following box if it applies, and describe as necessary.

Condition	Father	Mother	Spouse	Brother/Sister	Children
Arthritis					
Disc Problem					
Pinched Nerve					
Headaches					
Migraine					
Scoliosis					
Insomnia					
Asthma					
Emphysema					
Sinus Trouble					
Stomach Trouble					
Liver Trouble					
Kidney Trouble					
Epilepsy					
Heart Trouble					
High Blood Pressure					
Stroke					
Diabetes					
Cancer (Please List)					
Other:					

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

Signature of Patient ________________________________ Date: ________________