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

Chiropractic Case History/Patient Information

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

Legal Name:_____ Nickname/Preferred Name: _____

Social Security #_____ Cell Phone #: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Other Phone # :_____

Age:_____ Birth Date:_____ Marital Status: M S W D Preferred Contact Number (circle) : Cell Other

Occupation:_____ Employer:_____

Spouse's Name: _____ Spouse Birth Date:_____

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?_____

INSURANCE INFORMATION:

Information of Primary Insurance Company:_____

Information of Secondary Insurance Company (if any):_____

Name of person who carries the insurance policy:_____

DOB: _____

Address if different from above: _____

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

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:_____

    _____

    _____

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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 an " X " next to the 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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PATIENT NAME

_____

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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: _____