PROACTIVE CHIROPRACTIC AND REHAB CENTER
Ending your pain gently and quickly
11010 South Tryon St.
Suite 112
Charlotte, NC 28273
704-504-1770

Chiropractic Case History/ Patient Information

Date:_____ Patient #_____ Doctor:_____

Full Name:_____ Social Security #_____

Home Phone: _____ Cell Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____

Age:_____ Birth Date:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

How were you referred to our office?_____

Family Medical Doctor:_____

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

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work___ Other_____

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

_____

Days lost from work:_____ Date of last physical examination:_____

Past Medical History:

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Do you have a history of stroke or hypertension?_____
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 by a physician in the last year? π Yes π No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

Social History:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

Please check any and all insurance coverage that may be applicable in this case:
π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π 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 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.

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 you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____