# Chiropractic Case History/Patient Information

**Date:**________________ Patient #_______ **Doctor:**____________________

Name:___________________________ Home Phone: _________________ Cell Phone:_____________________

Address:_____________________________________City:___________________ State:______ Zip:___________

E-mail Address:_____________________________

Age:_______ Birth Date:___________ Race:_________Marital: M S W D

Occupation:__________________________ Employer:______________________________________________

Employer's Address:___________________________________ Office Phone:______________________________

Spouse:____________________ Occupation:________________ Employer:______________________________

How many children?__________Names and Ages of Children:___________________________________________

______________________________________________________________________________________

Name of Nearest Relative:______________________ Address:______________________Phone:_____________

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? ☐ Yes ☐ No

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 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. The following person(s) have my permission to receive my personal health information:**

______________________________________________________________________________________

______________________________________________________________________________________

Patient's Signature:______________________________________________________ Date:________________

Guardian's Signature Authorizing Care:____________________________________ Date:________________

PATIENT NAME ___________________________________________

DATE ____________________ Doctor_________________________

## HISTORY OF PRESENT AND PAST ILLNESS:

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? ☐ Yes ☐ No If yes, when? Describe:____________________

_____________________________________________________________________________________________

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

Treatments you received to help with your chief complaint:_____________________________________________

_____________________________________________________________________________________________

Have you ever visited a chiropractor? ☐ Yes ☐ No If yes, what is his/her name?_________________________

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

If yes, describe:_______________________________________________________________________________

Do you have a history of stroke or hypertension?____________________________________________

Do you have any congenital condition? ☐ Yes ☐ No If yes, describe: ____________________________________

Women: Are you pregnant? ☐ Yes ☐ No

What medications, drugs, herbs, 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:_______________________________________________________________________________

Major illnesses, injuries, falls, auto accidents or surgeries, including childbirth (include dates): _________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**SOCIAL HISTORY**

Please indicate the extent to which you engage in the following:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_______ Vigorous Exercise

______ Family Pressures

_______ Moderate Exercise

_______ Alcohol Use

_______ Drug Use

_______ Tobacco Use

_______ High Stress Activity

_______ Caffeine

______ Financial Pressures

______ Other Mental Stresses

______ Other (specify) ________________

____________________________________

PATIENT NAME ________________________________________

DATE ____________________ Doctor__________________________

Please indicate with the letter **N** if you have these symptoms/ conditions **now** or **P** if you have had these conditions **previously**.

CARDIOVASCULAR
___ Angina
___ Chest Pain
___ Circulation Problems
___ Claudication
___ Cold Feet/Hands
___ Heart Disease
___ Heart Murmurs
___ Heart Problems
___ High Blood Pressure
___ Low Blood Pressure
___ Orthopnea
___ Pacemaker
___ Palpitations
___ Shortness of Breath
___ Swelling of Legs
___ Varicose Veins

INTEGUMENTARY
___ Breast Lumps/Pain
___ Change in Nail Texture
___ Change in Skin Color
___ Eczema
___ Hair Growth/Loss
___ History of Skin Disorders
___ Hives/Itching
___ Paresthesia
___ Rash
___ Skin Lesions

NEUROLOGICAL
___ Change in Concentration
___ Change in Memory
___ Dizziness
___ Headache
___ Imbalance
___ Loss of Consciousness
___ Loss of Memory
___ Numbness
___ Numbness in Fingers/Toes
___ Seizures
___ Sleeping Problems
___ Slurred Speech
___ Stress
___ Strokes
___ Tremors

CONSTITUTONAL
___ Chills
___ Drowsiness
___ Fainting
___ Fatigue
___ Fever
___ Frequent Colds
___ Night Sweats
___ Weakness
___ Weight Gain
___ Weight Loss

EYES
___ Blindness
___ Blurred Vision
___ Cataracts
___ Change in Vision
___ Double Vision
___ Dry Eyes
___ Eye Pain
___ Glaucoma
___ Sensitivity to Light
___ Tearing
___ Wears Glasses

GASTROINTESTINAL
___ Abdominal Pain
___ Abnormal Stool Color
___ Abnormal Stool Consistency
___ Belching
___ Black, Tarry Stools
___ Constipation
___ Diarrhea
___ Gallbladder Problems
___ Heartburn
___ Hemorrhoids
___ Indigestion
___ Jaundice
___ Nausea
___ Rectal Bleeding
___ Unusual Bowel Patterns
___ Vomiting
___ Vomiting Blood

PSYCHIATRIC
___ Agitation
___ Alcoholism
___ Anxiety
___ Appetite Changes
___ Behavioral Changes
___ Bipolar Disorder
___ Confusion
___ Convulsions
___ Depression
___ Eating Disorder
___ Insomnia
___ Location Disorientation
___ Memory Loss
___ Nervousness
___ Substance Abuse
___ Suicidal
___ Time Disorientation

RESPIRATORY
___ Asthma
___ Bronchitis
___ Chest Pains/ Tightness
___ Coughing up Blood/Mucus
___ Difficulty Breathing
___ Difficulty Sleeping
___ Dry Cough
___ Hemoptysis
___ Pneumonia
___ Productive Cough
___ Sputum Production
___ Wheezing

GENITOURINARY
___ Birth Control Therapy
___ Burning Urination
___ Cramps
___ Difficulty Urinating
___ Erectile Dysfunction
___ Frequent Urination
___ Hesitancy/Dribbling
___ Hormone Therapy
___ Irregular Menstruation
___ Lack of Bladder Control
___ Prostate Problems
___ Urine Retention
___ Vaginal Bleeding
___ Vaginal Discharge

ENDOCRINE
___ Cold Intolerance
___ Diabetes
___ Excessive Appetite
___ Excessive Hunger
___ Excessive Thirst
___ Goiter
___ Heat Intolerance
___ Hyperthyroidism
___ Hypothyroidism
___ Voice Changes

HEMATOLOGIC/LYMPHATIC
___ Anemia
___ Bleeding
___ Blood Clotting
___ Blood Transfusions
___ Bruise Easily
___ Lymph Node Swelling

MUSCULOSKELETAL
___ Arthritis
___ Back Pain
___ Broken Bones/Fractures
___ Decreased Motion
___ Gout
___ Injuries
___ Joint Pain/Swelling
___ Joint Stiffness
___ Locking Joints
___ Muscle Cramps
___ Muscle Pain/Tension
___ Muscle Spasms
___ Muscle Weakness
___ Neck Pain/Stiffness
___ Osteoarthritis
___ Osteoporosis
___ Rheumatoid Arthritis
___ Shoulder/Arm Pain

ENMT
___ Bad Breath
___ Buzzing/Ringing in Ears
___ Dentures
___ Deviated Septum
___ Difficulty Swallowing
___ Discharge
___ Dry Mouth
___ Ear Drainage
___ Ear Infections
___ Ear Pain
___ Frequent Sore Throats
___ Head Injury
___ Hearing Loss
___ Hoarseness
___ Loss of Smell
___ Loss of Taste
___ Nasal Congestion
___ Nose Bleeds
___ Post Nasal Drip
___ Runny Nose
___ Sinus Infections
___ Snoring
___ Sore Throat
___ TMJ Problems
___ Ulcers

ALLERGIC/IMMUNOLOGIC
___ Cancer
___ History of Anaphylaxis
___ HIV Positive
___ Itchy Eyes
___ Sneezing
___ Specific Food Intolerance

PATIENT NAME ____________________________________________

DATE ____________________ Doctor__________________________

**FAMILY HISTORY**

Please review the diseases and conditions listed below and indicate those that are current health problems of the family member. Leave blank the spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

| CONDITION | FATHER Age [ ] | MOTHER Age [ ] | SPOUSE Age [ ] | BROTHER(S) Age [ ] Age [ ] | SISTER(S) Age [ ] Age [ ] | CHILDREN Age [ ] Age [ ] |
|---|---|---|---|---|---|---|
| Arthritis | | | | | | |
| Asthma-Hay Fever | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problem | | | | | | |
| Emphysema | | | | | | |
| Epilepsy | | | | | | |
| Headaches | | | | | | |
| Heart Trouble | | | | | | |
| High Blood Pressure | | | | | | |
| Insomnia | | | | | | |
| Kidney Trouble | | | | | | |
| Liver Trouble | | | | | | |
| Migraine | | | | | | |
| Nervousness | | | | | | |
| Neuritis | | | | | | |
| Neuralgia | | | | | | |
| Pinched Nerve | | | | | | |
| Scoliosis | | | | | | |
| Sinus Trouble | | | | | | |
| Stomach Trouble | | | | | | |
| Other: | | | | | | |
| | | | | | | |

If any of the above family members are deceased, please list their age at death and cause:

______________________________________________________________________

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

Name of Patient ______________________________________________________________

Signature of Patient/Legal Guardian ____________________________________________

Date ________________________

# INFORMED CONSENT

**Hartland Family Chiropractic LLC**
**Dr. Hans J. Halaska**
**211 Cottonwood Avenue Suite A**
**Hartland, WI 53029**
**Ph: (262)367-7424**
**Fax: (262)369-1068**

PATIENT NAME ____________________________________________________________

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE ______________________________

___________________________________
Printed Name

___________________________________
Signature

___________________________________
Signature of Parent or Guardian (if a minor)

Hartland Family CHIROPRACTIC

**Dr Hans J. Halaska**, 211 Cottonwood Avenue, Suite A Hartland WI, 53029
262-367-7424 ~ Fax: 262-369-1068
www.hartlandchiro.com

# 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)