

# 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:](#)**

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**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

\_\_\_\_\_ High Stress Activity

\_\_\_\_\_ Family Pressures

\_\_\_\_\_ Caffeine

\_\_\_\_\_ Moderate Exercise

\_\_\_\_\_ Financial Pressures

\_\_\_\_\_ Alcohol Use

\_\_\_\_\_ Other Mental Stresses

\_\_\_\_\_ Drug Use

\_\_\_\_\_ Other (specify) \_\_\_\_\_

\_\_\_\_\_ Tobacco Use

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**.

<b>CARDIOVASCULAR</b>	<b>CONSTITUTIONAL</b>	<b>EYES</b>	<b>RESPIRATORY</b>	<b>MUSCULOSKELETAL</b>
<input type="checkbox"/> Angina	<input type="checkbox"/> Chills	<input type="checkbox"/> Blindness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Circulation Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chest Pains/ Tightness	<input type="checkbox"/> Broken Bones/Fractures
<input type="checkbox"/> Claudication	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Coughing up Blood/Mucus	<input type="checkbox"/> Decreased Motion
<input type="checkbox"/> Cold Feet/Hands	<input type="checkbox"/> Fever	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Injuries
<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Dry Cough	<input type="checkbox"/> Joint Pain/Swelling
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Weakness	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Joint Stiffness
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Locking Joints
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Sensitivity to Light	<input type="checkbox"/> Productive Cough	<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Orthopnea		<input type="checkbox"/> Tearing	<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Muscle Pain/Tension
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Wears Glasses	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Muscle Spasms
<input type="checkbox"/> Palpitations				<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Shortness of Breath	<b>GASTROINTESTINAL</b>			<input type="checkbox"/> Neck Pain/Stiffness
<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Abdominal Pain	<b>GENITOURINARY</b>		<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Abnormal Stool Color	<input type="checkbox"/> Birth Control Therapy		<input type="checkbox"/> Osteoporosis
	<input type="checkbox"/> Abnormal Stool Consistency	<input type="checkbox"/> Burning Urination		<input type="checkbox"/> Rheumatoid Arthritis
<b>INTEGUMENTARY</b>	<input type="checkbox"/> Belching	<input type="checkbox"/> Cramps		<input type="checkbox"/> Shoulder/Arm Pain
<input type="checkbox"/> Breast Lumps/Pain	<input type="checkbox"/> Black, Tarry Stools	<input type="checkbox"/> Difficulty Urinating		
<input type="checkbox"/> Change in Nail Texture	<input type="checkbox"/> Constipation	<input type="checkbox"/> Erectile Dysfunction		<b>ENMT</b>
<input type="checkbox"/> Change in Skin Color	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Frequent Urination		<input type="checkbox"/> Bad Breath
<input type="checkbox"/> Eczema	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Hesitancy/Dribbling		<input type="checkbox"/> Buzzing/Ringing in Ears
<input type="checkbox"/> Hair Growth/Loss	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hormone Therapy		<input type="checkbox"/> Dentures
<input type="checkbox"/> History of Skin Disorders	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Irregular Menstruation		<input type="checkbox"/> Deviated Septum
<input type="checkbox"/> Hives/Itching	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Lack of Bladder Control		<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Paresthesia	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Prostate Problems		<input type="checkbox"/> Discharge
<input type="checkbox"/> Rash	<input type="checkbox"/> Nausea	<input type="checkbox"/> Urine Retention		<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Skin Lesions	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Vaginal Bleeding		<input type="checkbox"/> Ear Drainage
	<input type="checkbox"/> Unusual Bowel Patterns	<input type="checkbox"/> Vaginal Discharge		<input type="checkbox"/> Ear Infections
	<input type="checkbox"/> Vomiting			<input type="checkbox"/> Ear Pain
	<input type="checkbox"/> Vomiting Blood	<b>ENDOCRINE</b>		<input type="checkbox"/> Frequent Sore Throats
<b>NEUROLOGICAL</b>		<input type="checkbox"/> Cold Intolerance		<input type="checkbox"/> Head Injury
<input type="checkbox"/> Change in Concentration	<b>PSYCHIATRIC</b>	<input type="checkbox"/> Diabetes		<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Change in Memory	<input type="checkbox"/> Agitation	<input type="checkbox"/> Excessive Appetite		<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Excessive Hunger		<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Headache	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Excessive Thirst		<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Imbalance	<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Goiter		<input type="checkbox"/> Nasal Congestion
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Behavioral Changes	<input type="checkbox"/> Heat Intolerance		<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Hyperthyroidism		<input type="checkbox"/> Post Nasal Drip
<input type="checkbox"/> Numbness	<input type="checkbox"/> Confusion	<input type="checkbox"/> Hypothyroidism		<input type="checkbox"/> Runny Nose
<input type="checkbox"/> Numbness in Fingers/Toes	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Voice Changes		<input type="checkbox"/> Sinus Infections
<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression			<input type="checkbox"/> Snoring
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Eating Disorder	<b>HEMATOLOGIC/LYMPHATIC</b>		<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Slurred Speech	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Anemia		<input type="checkbox"/> TMJ Problems
<input type="checkbox"/> Stress	<input type="checkbox"/> Location	<input type="checkbox"/> Bleeding		<input type="checkbox"/> Ulcers
<input type="checkbox"/> Strokes	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Blood Clotting		
<input type="checkbox"/> Tremors	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Blood Transfusions		<b>ALLERGIC/IMMUNOLOGIC</b>
	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Bruise Easily		<input type="checkbox"/> Cancer
	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Lymph Node Swelling		<input type="checkbox"/> History of Anaphylaxis
	<input type="checkbox"/> Suicidal			<input type="checkbox"/> HIV Positive
	<input type="checkbox"/> Time Disorientation			<input type="checkbox"/> Itchy Eyes
				<input type="checkbox"/> Sneezing
				<input type="checkbox"/> 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 oculosympathetic 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 \_\_\_\_\_  
Name

Date \_\_\_\_\_

Print Patient's

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)