Mason Chiropractic Health & Wellness 1441 New Hwy 96 West Suite 3 615.794.9155 www.MasonChiro.net

Chiropractic Case History/Confidential Patient Information

Today's Date:_____/_____/______

Patient's Full Name:____

Office Use Only:
Patient ID#:____________

ABOUT YOU:

What Name You Prefer to Be Called: ________________________________ Male____ Female____

Home Phone: __________________Cell Phone: __________________ E-Mail: ____________________________

Address:_____________________________________City:___________________ State:______ Zip:____________

SS#:________-________-__________ Age:_________ Birth Date:______/______/_______

Status: Minor____Single____Married____Widowed____Divorced____ Do you have children?______________

Occupation:_________________________ Employer:____

Employer's Address:___________________________________ Phone:___________________________________

Spouse:___________________ Occupation:________________ Employer:________________________________

Emergency Contact:________________________ **Relationship**: __________________**Phone**:______________

How were you referred to our office?____

Family Medical Doctor:____ Office Location/Area: _________________

For your benefit, may our office update your medical doctor regarding your care at this office? Yes___ No___

PRESENT CONDITION:

Reason for visit (Chief Complaint):____

Date or time frame symptoms appeared:_____________________ Was the Onset: Gradual____Sudden___ Chronic___

Please describe the pain & its location: ____

Is this due to: Auto___ Work____ Sport____ Other____

If today's visit is due to a Personal Injury or Auto Accident, please check with receptionist, additional info is needed.

Have you ever had the same or a similar condition? Yes ___ No___ If yes, when and describe:___________________

____

Is the condition getting worse? Yes ____No ____; Frequency of symptoms? Constant ____Comes and goes____

Does this condition interfere with your: Work ___Sleep ___Daily Routine ___Recreation ____

What treatment have you already received for you condition? Meds___ Surgery___ PT___ Chiropractic___ Other______

PAST HEALTH HISTORY:

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

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Heart Disease
__Circulatory Problems	__Epilepsy	__Alcoholism	__Thyroid Problems
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Diabetes
__Seizures/Convulsions	__Strokes	__HIV Positive	__Artificial Joints/Hardware
__A Congenital Disease	__Cancer	__Gall Bladder	__Frequent Neck Pain
__Excessive Bleeding	__Herniated Disk	__Depression	__Lower Back Problems
__High/Low Blood Pressure	__Coughing Blood	__Ulcers/Colitis	__Severe/Frequent Headaches

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

What medications or drugs are you taking?____

____

Do you have any allergies of any kind? Yes___ No___If yes, describe:_______________________________________

SOCIAL HISTORY:

What are your hobbies?____

Do you exercise? Yes___ No___If yes, what is the frequency and type of exercise?_______________

Do you drink alcoholic beverages? Yes___ No___ If so, how much per week?__________________

Do you use any tobacco products? Yes___ No___ If you smoke, how long and how many packs per day?______

Do you take vitamins or supplements?________ If so, please list:_______________________

Do you consume caffeine? Yes___ No___ If so, how much per day:_______________________

Do you eat a balanced low fat diet? Yes___ No___ If no, explain:______________________

Do you get adequate sleep? Yes___ No___ If no, explain:_____________________________

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_______ heavy labor______

FAMILY HISTORY:

Please list any diseases, disorders, or major illnesses (examples: Cancer, Diabetes, Stroke, Heart Disease, Multiple Sclerosis, Liver or Kidney Disease, Arthritis) in your family's medical history. If deceased, from what?

1. Mother: ____
2. Father: ____
3. Sisters: ____
4. Brothers:____
5. Other: ____

OTHER INFO:

How do you prefer to sleep? Back___ Side ___ Stomach ___

Do you wear orthotics or arch supports? Yes ___ No____

What type of care are you interested in:
Pain Relief only____ Healing of current condition____ Optimizing your health____ All three!____

ACCOUNT & INSURANCE INFO:

Who is ultimately responsible for this account? (If same as above in **About You**, put "same" and proceed to Payment Method)

Name:_________________________________ Relation to patient:__________________

Billing Address: _______________________ City:________________ State: _____ Zip:________

SS#:________-________-__________ D.L#_______________________

Payment Method: Cash____ Check____ Credit Card_____ Insurance_____ (payment plans and financing are available upon request and will be presented as an option to you during your report of findings on the second visit)

Do You Have Health Insurance? Yes ____ No____ If Yes, please let us make copies of your insurance card(s), and check any and all insurance coverage that may be applicable in this case**:**
___Major Medical ___Worker's Compensation ___Medicare ___Auto Accident ___AmeriPlan/Uni-Care
___Medical Savings Account & Flex Plans ___Other

Name of Primary Insurance Company:___________________________________
Insured ID#:___________________________ Group#: ________________________

Name of Secondary Insurance Company (if any):___________________________
Insured ID#:___________________________ Group#: ________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Mason Chiropractic Health & Wellness, Inc.
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 you do not want to receive your medical records, please inform our office.

Patient's Signature:_________________________________ Date:______________

Guardian's Signature Authorizing Care:_______________________ Date:______________