

Forbes Family Chiropractic, PC
115 S. Filbert St., Mechanicsburg, PA 17055
Chiropractic Case History/Patient Information

Date: _____ **Patient #** _____ **Doctor:** Kevin M. Forbes, D.C.

Name: _____ **Social Security #** _____ **Home Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail address: _____ **Fax #** _____ **Cell Phone:** _____

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:** _____

Emergency Contact Name: _____ **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? _____

HISTORY OF PRESENT 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 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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers |

Do you have a history of stroke or hypertension (high blood pressure)? _____

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? Yes No

If yes, describe: _____

What medications or drugs 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: _____

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 _____

FAMILY HISTORY:

Parents:

Father: living ____ deceased ____ Current age if still living: ____ Cause of death and age at death if deceased: _____

Mother: living ____ deceased ____ Current age if still living: ____ Cause of death and age at death if deceased: _____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis _____	Cancer _____	Mental Illness _____
Diabetes _____	Asthma _____	Heart Disease _____
Stroke _____	Kidney Disease _____	Lung Disease _____
Arthritis _____	Liver Disease _____	
Other _____		

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. 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: _____

SUMMARY

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 unrelated health problems? Yes ___ No _____. If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. 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? _____

8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
11. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____

Pain Drawing – Patient Please Fill Out

Patient ID: _____ Date: _____

Date of Birth: _____ Examiner: Kevin M. Forbes, D.C.

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>>

Burning x x x x

Numbness = = = = =

Stabbing // // //

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~

