Chiropractic Case History/Patient Information

Date:__________________ Patient #__________ **Doctor:_Dr. Ben McDowell**_________

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:_________________________________
____
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?__________
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__Dr. Ben McDowell___________________

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 and describe:______________

____

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

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? ☐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? π Yes π No

If yes, describe:____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe ______________________________

Women: Are you pregnant?___________________

PATIENT NAME ____

DATE ____________________ Doctor__________________________

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches______ Frequency	________	Loss of Balance	___________
Neck Pain	________	Fainting	___________
Stiff Neck	________	Loss of Smell	___________
Sleeping Problems	________	Loss of Taste	___________
Back Pain	________	Unusual Bowel Patterns	___________
Nervousness	________	Feet Cold	___________
Tension	________	Hands Cold	___________
Irritability	________	Arthritis	___________
Chest Pains/Tightness	________	Muscle Spasms	___________
Dizziness	________	Frequent Colds	___________
Shoulder/Neck/Arm Pain	________	Fever	___________
Numbness in Fingers	________	Sinus Problems	___________
Numbness in Toes	________	Diabetes	___________
High Blood Pressure	________	Indigestion Problems	___________
Difficulty Urinating	________	Joint Pain/Swelling	___________
Weakness in Extremities	________	Menstrual Difficulties	___________
Breathing Problems	________	Weight Loss/Gain	___________
Fatigue	________	Depression	___________
Lights Bother Eyes	________	Loss of Memory	___________
Ears Ring	________	Buzzing in Ears	___________
Broken Bones/Fractures	________	Circulation Problems	___________
Rheumatoid Arthritis	________	Seizures/Epilepsy	___________
Excessive Bleeding	________	Low Blood Pressure	___________
Osteoarthritis	________	Osteoporosis	___________
Pacemaker	________	Heart Disease	___________
Stroke	________	Cancer	___________
Ruptures	________	Coughing Blood	___________
Eating Disorder	________	Alchoholism	___________
Drug Addiction	________	HIV Positive	___________
Gall Bladder Problems	________	Depression	___________
Ulcers	________		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= “O” SOMETIMES= “S” NEVER= “N”

___________ Vigorous Exercise	__________ Family Pressures
___________ Moderate Exercise	__________ Financial Pressures
___________ Alcohol Use	__________ Other Mental Stresses
___________ Drug Use	__________ Other (specify)______
___________ Tobacco Use	______________________________
___________ Caffeine	_______________________________
___________ High Stress Activity	

PATIENT NAME ____

DATE ____________________ Doctor_________________________

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those 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 [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood 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 ____

DOCTOR __Dr. Ben McDowell

DATE OF VISIT ___/___/20___ Patient____ Age_________________

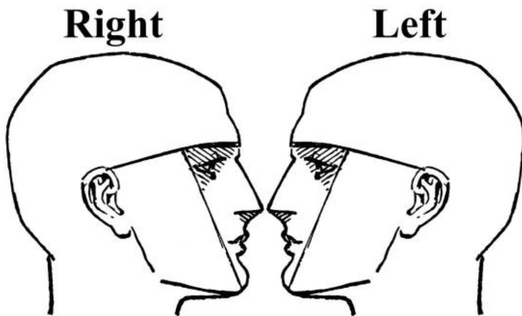
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

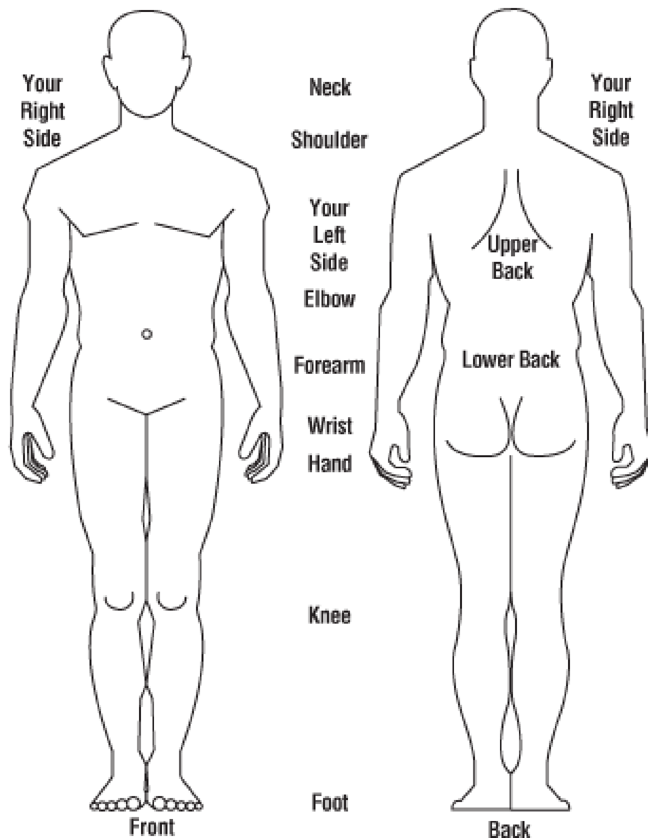
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ____________

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ______________________

____

SUBJECTIVE PAIN ASSESSMENT





RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			

EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

____ ________________

INFORMED CONSENT

PATIENT NAME ______________________________

Clinic Name McDowell Chiropractic

Doctor's Name Dr. Ben McDowell

Address 1570 Holcomb Bridge Rd., Suite 550, Roswell, GA 30076

Phone 770-599-7139 Fax 844-818-5260

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 compilations 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 you clinical history.

DATE ______________________________

____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if a minor)