Neneman Chiropractic Clinic, P.C.

Dr. Nick Neneman

Confidential Patient Information/Health History

Date:__________________

Name:___________________________ Social Security #___________________Home Phone: ________________

Address:_______________________________________City:____________________ State:______ Zip:___________

E-mail address:______________________________Fax # ___________________ Cell Phone:___________________

Age:_______ Sex:______ Birth Date:___________ Race:______ Marital: M S W D

Occupation:___________________________ Employer:____

Employer's Address:_____________________________________ Office Phone:_______________________________

Spouse's Name:____________________ Occupation:_________________ Employer:___________________________

How many children?____________Names and Ages of Children:____

____

Name of emergency contact:_____________________ Address:_____________________Phone:________________

How were you referred to our office?____

Family/Personal 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?___________

Reason For Visit:

Chief Complaint: Purpose of this appointment:____

Is condition due to an accident?____

Date symptoms appeared or accident happened:____

Is this due to: Auto___ Work____ Other____

To whom have you made a report of your accident? Auto Insurance__ Employer__ Worker Comp__ 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

Do you have or ever had any of the following diseases or conditons? (Place a check mark by conditions that apply to you)

__Heart Attack
__Strokes
__Heart Surgery/Pacemaker
__Heart Murmur
__High Blood Pressure
__Excessive Bleeding
__Anemia
__Seizures/Epilepsy
__Severe/Frequent Headaches
__Migraine Headaches
__Dizziness/Fainting
__Sinus Problems
__Frequent Neck Pain
__Lower Back Problems
__Changes in bowel/bladder Function

__Osteoarthritis
__Rheumatoid Arthritis
__Diabetes
__Cancer
__Coughing Blood
__Tuberculosis
__Asthma
__Emphysema
__Difficulty Breathing
__Allergies
__Fibromyalgia
__Artificial Bones/Joints
__Osteoporosis
__Psychiatric Problems
__Depression

__Hepatitis
__HIV+/AIDS
__Kidney Problems
__Liver Problems
__Ulcers/Colitis
__Crohn's Disease
__Heartburn/Indigestion
__Irritable Bowel Syndrome
__Gallbladder Problems
__Arm/Hand Pain
__Leg/Foot Pain
__Hiatal Hernia
__High Cholesterol
__Chicken Pox
__Shingles

__Difficulty starting/stopping urination
__Bladder Infections/UTI's
__Prostate Problems
__Post-Menopausal
__Alcohol/Drug Abuse
__Pancreatitis
__Ear Infections
__Jaw Pain
__Thyroid Problems
__Multiple Sclerosis
__Parkinson's Disease
__Brain/Spinal Cord Tumors
__Other____________________

Has a physician treated you for any other condition(s) in the past 12 months? (If yes, please explain) Yes No
____
Doctor's
Notes:____
____
____
____

Please describe for us any hospitalizations, serious illnesses, falls, broken bones, or surgeries you have had:

Year Reason Hospital Outcome
____
____
____
____

Please list your prescribed medications, over-the counter medications, supplements, vitamins, herbs, and inhalers:

Name Dosage Frequency Used Used For
____
____
____
____
____
____

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?____
Stress Level (Low)1 2 3 4 5 6 7 8 9 10 (High)
Which positions or activities are you involved with daily at home or at work:
Lifting_____ Sitting_____ Standing______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____________________ (check one)
Mother: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:_____________________ (check one)

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 **F**ather, **M**other, **S**ister, **B**rother, **G**randparent):

High Blood Pressure____
Diabetes ____
Stroke ____
Heart Disease_____
Bleeding Disorders ______
Immune Disorders_____
Arthritis_____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____
Thyroid Disease___
Gastrointestinal___
Genitourinary___

Mental Illness____
Depression ____
Lung Disease____
Skin Disease____
Neurological____
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:______________

Patient Case History

1. What is your major symptom/complaint?____

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 ___

   Morning 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. Does the pain radiate to a different location on the body?________________________________

8. 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? ______________

   ____

9. Have you seen another physician for this problem?_____________________________________

10. Have you seen a chiropractor before?____

11. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

    Lifting _____ Twisting _____ Other ____

12. List any major accidents you have had other than those that might be mentioned above: _______

    ____

13. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

14. Doctor Remarks: ____

    ____

    ____

15. Circle the number that most accurately describes your pain level, 0 being no pain at all, 10 being the most severe pain you have ever had.

    No Pain Worst Pain Ever

    0 1 2 3 4 5 6 7 8 9 10

Doctor's Signature ____ Date _____________