

Chiropractic Case History/Patient Information

Date: _____ **Patient #** _____ **Dr. Hielscher DC**

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

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

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

Age: _____ **Birth Date:** _____ **Race:** _____ **Marital:** M S W D

Occupation: _____ **Employer:** _____

Spouse: _____ **Occupation:** _____

Names and Ages of Children: _____

Emergency Contact: _____ **Relation:** _____ **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.

Permission for communication:

Norco Chiropractic values secure, effective and efficient communication. At any time during your care here, we may contact you via phone, email, text and may have a need to leave a voicemail. Please let us know if there is/are any forms of communication that we mentioned that you wish for us NOT to utilize with you.

Please do not contact me via the following: _____

Patient's Signature: _____ **Date:** _____
Guardian's Signature Authorizing Care: _____ **Date:** _____

PATIENT NAME _____

DATE _____

Dr. Hielscher DC

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: _____

Average pain intensity: please circle

Last 24 hours: no pain 1 2 3 4 5 6 7 8 9 10

Past week: no pain 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms? Please circle

Constantly (76%-100% of the time) Frequently (51%-75% of the time)

Occasionally (26%-50% of the time) Intermittently (0%-25% of the time)

How much have your symptoms interfered with your usual daily activities? Please circle

1-not at all 2- A little bit 3-Moderately 4-Quite a bit 5- Extremely

In general, would you say your overall health right now is...please circle

1-Excellent 2-Very good 3-Good 4-Fair 5-Poor

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: _____

Do you have any Congenital Condition? ___ Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

Pain Drawing

Name: _____

Date: _____

Dr. Hielscher DC

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 >>>>>

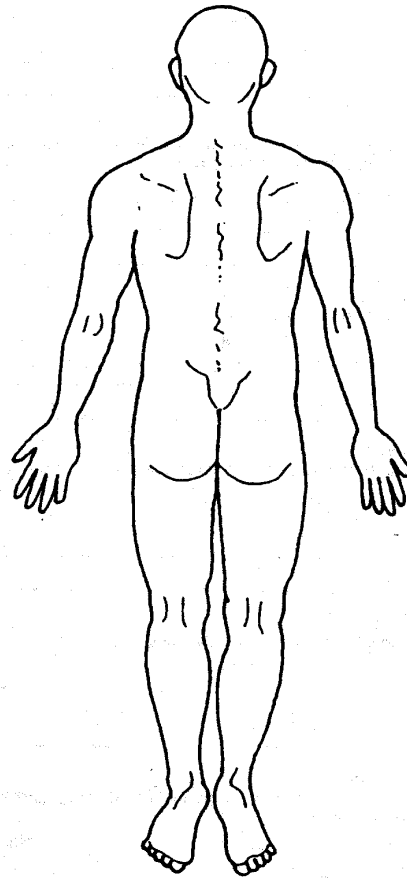
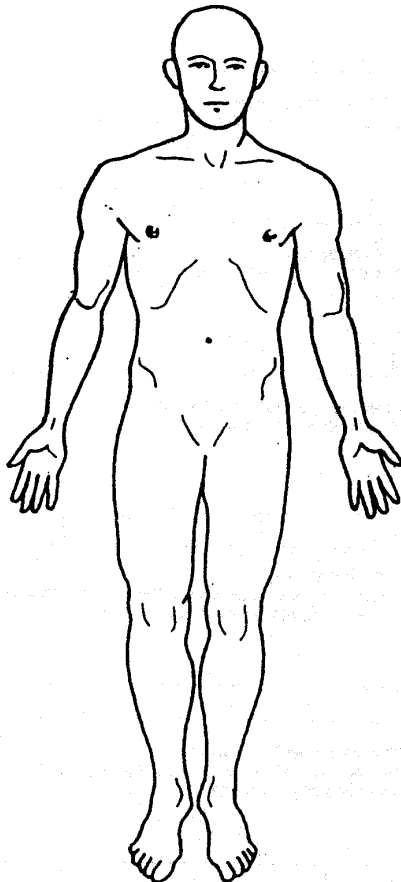
Numbness =====

Pins & Needles o o o o

Burning x x x x

Stabbing // // // //

Throbbing ~ ~ ~ ~ ~



0=No pain, 10=most severe pain

What is your current pain level: _____/10

What is your average pain level: _____/10

What is your worst pain level: _____/10

What is your lowest pain level: _____/10

Name: _____

Date: _____

Dr. Hielscher DC

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

C=Current P= Previous

- | | | | |
|---------------------------------|-------|------------------------|-------|
| Breathing Problems | _____ | Weight Loss/Gain | _____ |
| Fatigue | _____ | Ulcers | _____ |
| 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 | _____ | Alcoholism | _____ |
| Drug Addiction | _____ | HIV Positive | _____ |
| Gall Bladder Problems | _____ | Depression | _____ |
| 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 | _____ |

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Moderate Exercise

_____ Family Pressures

_____ Alcohol Use

_____ Other Mental Stresses

_____ Drug Use

_____ High Stress Activity

_____ Tobacco Use

_____ Other (specify) _____

_____ Caffeine

Name: _____

Date: _____

Dr. Hielscher DC

Family History: please list any family members who have had any of the following.

ADD/ADHD _____
 Alcoholism _____
 Hearing deficiency _____
 Allergies _____
 Hypertension _____
 Arthritis _____
 Irritable bowel disease _____
 Asthma _____
 Learning disability _____
 Blood disorder _____
 Mental illness _____
 Cancer _____
 Migraines _____
 Cardiovascular disease _____

Obesity _____
 Coronary Artery disease _____
 Osteoporosis _____
 Depression _____
 Renal disease _____
 Seizure disorder _____
 Developmental delay _____
 Diabetes _____
 Stroke _____
 Eczema _____
 Thyroid disorder _____
 Elevated Lipids _____
 Other _____

About You

What are your hobbies?

What are your Goals for care? Check what applies.

- Come as I please for pain relief
- Commit to a care plan to correct my problem(s)
- Maintenance care

Norco Chiropractic wishes to help as many people as possible to feel better, be able to do what they want and to be a resource and a healthcare provider that can be a trusted part of your team. We wish not to force any specific care on anyone and understand that healthcare is a personal choice that is influenced by time, money, pain, disability, convenience and lifestyle.

Dr. Wes' Promise to You

It is my mission to thoroughly exam and diagnose you, to educate you on your problem(s), to illustrate what your options of care are and to help you understand what you need. I will be here for any level of care you decide to receive and promise not to abuse the privilege of being one of your Doctors. Please feel free to communicate anything to me that is on your mind, ask questions and be involved in your health with me.

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____ Signature _____ Date _____