Chiropractic Case History – Dr. Spurgeon – Healing Neck & Joints

Name_____Sex M F Date_____

Address_____City_____ State_____Zip_____

H. Phone(_____)_____W. Phone_____ Date of Birth_____ Age_____

Email_____Referred by_____SocialSecurity#_____

Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature (Self/Guardian) _____ Date _____

Doctors Signature _____ Date _____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I understand and am informed that chiropractic care does have some associated risks and side effects. I understand there can be soreness, occasional headache or dizziness, and other mild side effects that can be experienced after treatment. And while rare, there are also more serious risks to treatment. These more serious risks include but are not limited to; fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the procedure which he or she feels at the time, based upon the facts then known to him or her, is in my best interest.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. Or I accept responsibility to bring up any questions or concerns I may have to the doctor and/or other aforementioned persons prior to any treatment being performed.

I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

Dr. Spurgeon, DC - Healing Neck & Joints
8643 Hauser Ct, Ste 240, Lenexa, KS 66215
(913) 353-6655

Insurance Assignment and Release

I hereby certify that I (or my dependent) have (health or accident) insurance coverage with _____, and authorize and direct my insurance benefits to be paid directly to Spurgeon Chiropractic Clinic, LLC. I take responsibility for verifying my insurance benefits, and I understand that I am financially responsible for all services rendered to me. I am aware any charges that are not covered by insurance are my responsibility to pay immediately. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____
Dependent Name (if applicable): _____

If you are not the primary insured person on your policy, please indicate who is and your relationship to them.

Primary Insured Name and Date of Birth: _____ DOB: ___/___/___
Relationship to Primary Insured: _____

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