

Date \_\_\_\_\_

# Your Case History

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ How long \_\_\_\_\_

Single  Married  Divorced  Widowed Spouse's Name \_\_\_\_\_

Children's names and ages \_\_\_\_\_

Payment preference:  Cash  Check  Bank Card  Care Credit (on available credit)

If insured, which insurance company will you be billing? \_\_\_\_\_

Policy number \_\_\_\_\_ Insurance company phone (\_\_\_\_\_) \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

## What can we help you with?

Check all that apply

- Optimum performance and wellness lifestyle
- General return to good health
- Subluxation detection and correction
- Specific complaint (Please describe) \_\_\_\_\_

If you are experiencing pain, is it:  Sharp  Dull  Burning  Achy  Stiff  Comes and goes  
Check all that apply  Constant  Radiating  Mild  Moderate  Severe

Others consulted for the same or similar health challenge \_\_\_\_\_

If injured, please briefly describe date and nature of onset \_\_\_\_\_

How does your health challenge affect your:

Work \_\_\_\_\_

Relationships \_\_\_\_\_

Play Time \_\_\_\_\_

Please rate the following statements from 1 to 10. 1 is the lowest, 10 is the highest.



The healthiest you have ever been in your life \_\_\_\_\_

Your current level of health \_\_\_\_\_

Your desire for a lifetime of health \_\_\_\_\_

**Tahoe City Chiropractic**  
"Optimum Care for your Active Lifestyle"

# Dis-ease Process

Answer these questions as they relate to **Your Childhood History**

|  | YES                      | NO                       | MAYBE                    |  | YES                      | NO                       | MAYBE                    |
|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Did you fall while learning to walk?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Did you use prescription drugs as a child?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you play any contact sports?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any car accidents as a child?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Any physical trauma as a child?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were you vaccinated?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you have any falls as a child?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any allergies as a child?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you picked on by siblings?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Did you have frequent colds as a child?      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Any emotional trauma as a child?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were you under chiropractic care as a child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were/are you exposed to second hand smoke? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Did you eat a healthy diet as a child?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you use over the counter drugs?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Did you have any other accidents?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Answer these questions as they relate to **Age 18 or over**

|                                       | YES                      | NO                       | MAYBE                    |                                       | YES                      | NO                       | MAYBE                    |
|---------------------------------------|--------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------------------|
| Have you had any surgery?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any car accidents?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any wild slips or falls? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever fallen on the ice/snow? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you fallen off a bike?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do/did you lift small children?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is your bed adequate and up to date?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you sleep well?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do/did you smoke?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lift heavy weights?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you watch your posture?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use prescription drugs?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you sit excessively?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use over the counter drugs?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other accidents?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## Please check any symptom that you have ever experienced

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pain after eating          | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Limited motion in neck     |
| <input type="checkbox"/> Visual changes       | <input type="checkbox"/> Pain relieved by eating    | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Mid back pain              |
| <input type="checkbox"/> Ear infections       | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Bone infection          | <input type="checkbox"/> Muscle spasm in back       |
| <input type="checkbox"/> Pain in ears         | <input type="checkbox"/> Change in stool color      | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Loss of motion in mid back |
| <input type="checkbox"/> Loss of hearing      | <input type="checkbox"/> Frequent urination         | <input type="checkbox"/> Fracture of bone        | <input type="checkbox"/> Low back pain              |
| <input type="checkbox"/> Sinus infection      | <input type="checkbox"/> Difficult urination        | <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Sciatica                   |
| <input type="checkbox"/> Frequent colds/flu   | <input type="checkbox"/> Bladder infection          | <input type="checkbox"/> Weight loss             | <input type="checkbox"/> Loss of motion in low back |
| <input type="checkbox"/> Stiff neck           | <input type="checkbox"/> Premenstrual syndrome      | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Muscle spasm in low back   |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Menstrual cramps           | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Numbness in hands/arms     |
| <input type="checkbox"/> Leg pain on exertion | <input type="checkbox"/> Irregular menstrual cycles | <input type="checkbox"/> Neck Pain               | <input type="checkbox"/> Numbness in feet/legs      |
| <input type="checkbox"/> Leg pain at rest     | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Neck feels out of place |   |

## Family Health History Please list all concerns

Children \_\_\_\_\_ Spouse \_\_\_\_\_  
 Mother \_\_\_\_\_ Father \_\_\_\_\_  
 Brothers \_\_\_\_\_ Sisters \_\_\_\_\_  
 Grandparents \_\_\_\_\_ Others \_\_\_\_\_

## Health Process

|                           | YES                      | NO                       | MAYBE                    |   | YES                      | NO                       | MAYBE                    |
|---------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Do you get good rest?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink quality water?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you eat quality food?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you get along with friends and family? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you exercise properly? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you get regular spinal adjustments?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I agree to allow this office to examine me to determine if I am eligible for chiropractic care. I further agree that the primary purpose of my relationship with this office is my desire to pursue the detection and correction of my chiropractic subluxations. I agree to keep an open line of communication with this office and I will do my best to maintain a healthy lifestyle.

SIGNATURE

DATE

PARENT OR GUARDIAN (IF UNDER 18 YEARS)

Patient Name \_\_\_\_\_

Birth Date \_\_\_\_\_

**INFORMED CONSENT: CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by Dr. Schroeder and/or his office staff who may now or in the future treat me in this office.

I have had an opportunity to discuss with the doctor and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but 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, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as the known, is in my best interests.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any other future condition(s) for which I seek treatment.

\_\_\_\_\_  
Patient/Guardian Signature Date

\_\_\_\_\_  
Doctor's Signature Date

\_\_\_\_\_  
Witness Signature Date

## **Consent for Release of Protected Health Information and Acknowledgement of Receipt of Privacy Practices**

I consent to the use or disclosure of my protected health by Tahoe City Chiropractic (TCC) for the purposes of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TCC. **I understand that diagnosis or treatment of me by any practitioner associated with TCC may be conditioned upon my consent as evidence by my signature on this document.**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TCC is not required to agree to the restrictions that I may request. However, if TCC agrees to a restriction that I request, the restriction is binding to TCC on any practitioner associated with TCC.

I have the right to revoke this consent, in writing, at any time, except to the extent that TCC or any practitioner associated with TCC has taken action in reliance on this consent. I understand, however, that doing so will result in immediate termination of my status as a patient at TCC, as my signature on this document is a condition of treatment here.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

**I understand I have the right to review this office's Notice of Privacy Practices (NPP) prior to signing this document. TCC's NPP has been offered to me for my review.** The NPP describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of TCC. The NPP also describes my rights and TCC's duties with respect to my protected health information.

TCC reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

In our office chiropractic adjustments are generally performed in an open environment. Every attempt will be made to protect your health care information. It is possible that conversations with the doctor may be overheard or written information may be incidentally noted. We do make every effort to protect your privacy. **If you desire a private room for health care conversation or treatment we will provide you with one at your request.**

**My signature below indicates that I have read and understand the above and agree to its provisions. It further acknowledges that I have been given a copy of the NPP.**

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Authority of Personal Representative