Chauvin Chiropractic Clinic
1000 Wildcat Drive
Abbeville, LA 70510
(337) 893-5252

PATIENT CASE HISTORY FORM

DATE__________________ CHART # ______________ HOME PHONE ___________________ WORK ___________________

NAME ____ SSN____________________ CELL ____________________

ADDRESS ____________________________________ CITY _________________________ STATE _________ ZIP ___________

AGE ___________ BIRTHDAY ________________ RACE _________ MARITAL STATUS _____________ # OF CHILDREN ______

OCCUPATION ___________________________________ EMPLOYER ____

NAME OF SPOUSE _______________________________ OCCUPATION _____________________ EMPLOYER _____________

EMERGENCY CONTACT ___________________________ PHONE ___________________________ MD ___________________

EMAIL _______________________ WHO MAY WE THANK FOR REFERRING YOU? ___________________________________

PREFERRED NAME (how you would like to be addressed) ____

REASON FOR VISIT

HAVE YOU BEEN INVOLVED IN ANY ACCIDENTS _____________________ DAYS LOST FROM WORK ____________________

WHAT SYMPTOMS ARE YOU EXPERIENCING TODAY ____

DATE STARTED _____/_____/_____ HOW LONG DOES LAST __________________ SERIOUS ILLNESS __________________

SURGERIES ____

MEDICATION YOU ARE CURRENTLY TAKING____

PLEASE CHECK OFF THE INSURANCE YOU WOULD LIKE FOR US TO FILE FOR YOU

MEDICARE ____________ MAJOR MEDICAL _____________

NAME OF INSURANCE COMPANY _______________________________________ POLICY # __________________________

2ND INSURANCE ____ POLICY # __________________________

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 payers 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. I understand that should the account be referred to an attorney or collection, the patient and/or person(s) having legal power of attorney for the patient will be responsible for all service charges, court cost, interest, collection agency fees reasonable attorney fees and all collection expenses involved to collect this debt.

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 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.

PATIENT SIGNATURE ____ DATE ________________________________

PATIENT'S NAME ____

1. What is your major symptom? ____
2. 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? ____
3. How frequent is the condition? Constant ________ Daily ________ Intermittent ________ Night Only ________

   How long does it last? All Day ______________ Few Hours ______________ Minutes _________________
4. 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 _________________________
5. Describe the pain: Sharp ________ Dull ________ Numbness ________ Tingling ________ Aching ________

   Burning _________ Stabbing _________ Other ____
6. Is there anything you can do to relieve the problem? Yes _____ No _____ If yes, describe, If no, what have you

   done that has not helped?____
7. What makes the problem worse? Standing _________ Sitting _________ Lying ________ Bending ________

   Lifting ________ Twisting ________ Other ____
8. Have you had any broken bones? Yes ________ No ________ If yes, please list and give dates ______________

   -____
9. List any major accidents you have had other than those that might be mentioned above: ___________________

   -____
10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the

    past or the present? Yes ______ No ______ If yes, please explain ____________________________________

    -____
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____
12. Remarks: ____

    -____

NO SYMPTOMS — EXTREME SYMPTOMS

[____]

Please place an X on the line above to that best describes the pain 1 to 10 being the worst.

Doctor's Signature ____ Date _________________________