



Office Use:  
Acct # : \_\_\_\_\_  
Date of Last Adj: \_\_\_\_\_

# Chiropractic Case History/Patient Information

**Kaile Myrick, D.C.**  
**(719) 599-8682**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Name Preferred: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Names/Ages Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you **referred** to our office? \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

Please circle any and all insurance/coverage options that may be applicable to your case:

*Major Medical Worker's Compensation Medicare Auto Accident Medical Savings*

*Account & Flex Plans CareCredit Other: \_\_\_\_\_*

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Core Chiropractic, LLC. 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. The following person(s) have my permission to receive my personal health information:**

\_\_\_\_\_  
\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_



### HISTORY OF PRESENT ILLNESS

**Chief Complaint(s):** Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Have you ever had the same or a similar condition(s)? \_\_\_\_\_ If yes, when and describe: \_\_\_\_\_

How did it originally occur? \_\_\_\_\_

Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_

If yes, when and how? \_\_\_\_\_

How frequent is the condition? Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only \_\_\_ Morning \_\_\_

How long does it last? All Day \_\_\_ Few Hours \_\_\_ Minutes \_\_\_

Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_ Burning \_\_\_

Stabbing \_\_\_ Other \_\_\_\_\_

What relieves the problem? \_\_\_\_\_

What aggravates the problem? \_\_\_\_\_

What does this prevent you from doing or enjoying? \_\_\_\_\_

Days lost from work: \_\_\_\_\_ Work Duties: \_\_\_\_\_

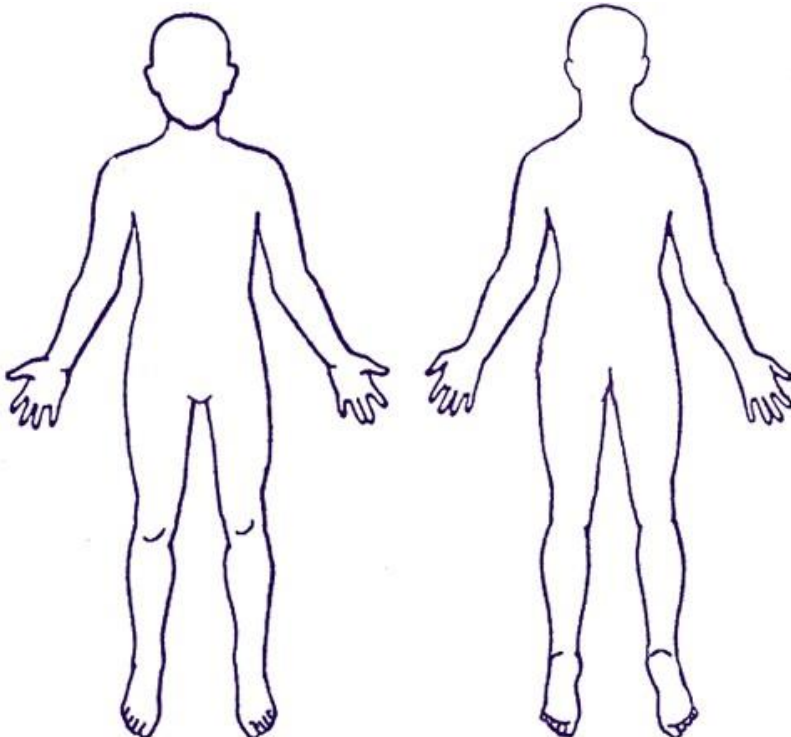
Are there any other conditions or symptoms that may be related to your major symptom? Yes \_\_\_ No \_\_\_

If yes, describe: \_\_\_\_\_

**NO SYMPTOMS**

**EXTREME SYMPTOMS**

Please place an "X" on the line above to indicate level of problem.



#### SUBJECTIVE PAIN ASSESSMENT

*Indicate the location of your symptoms on the drawing using the following description:*

- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing
- ← =Shooting or traveling

*Example: ST placed between the shoulder blades indicated stabbing pain in that location.*



HEALTH HISTORY

List ALL major illnesses, injuries, falls, auto-accidents or surgeries over lifetime. Doctors determine relevance.

Have you been treated for any health condition by a physician in the last year? Yes No
If yes, describe:

What medications, drugs, or supplements are you taking? For medications, list what it is being used to treat, and how long you have been taking it.

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? Previous childbirth vaginal or cesarean

Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.
"N" = Now "P" = Previously

Headaches Frequency Location
Neck Pain or Stiffness
Back Pain or Stiffness
Numbness/Tingling Location
Loss of Strength Location
Arthritis Location Type
Bones/Fractures Location
Joint Pain/Swelling Location
Muscle Spasms Location

Frequent Colds Type
Fever
Fatigue Reason
Weight Loss or Gain (circle) Amount Timeframe
Diabetes
Osteopenia or Osteoporosis (circle)
Cancer Type Treatment
HIV Positive

Sleeping Problems Due to: pain or busy mind (circle)
Nervousness Cause
Tension Cause
Irritability Cause
Depression Cause
Loss of Memory
Loss of Balance
Dizziness
Fainting
Seizures
Ears Ring or Buzz
Loss of Taste
Loss of Smell
Trouble with Eyes Describe
Eating Disorder Type
Drug Addiction
Alcoholism

Heart Disease
High Blood Pressure
Low Blood Pressure
Chest Pain/ Tightness
Shoulder/Arm/Neck pain
Circulation Problems
Hands/Feet Cold
Excessive Bleeding
Stroke
Pacemaker

Indigestion
Ruptures Location
Gall Bladder Problems
Ulcers
Unusual Bowel Patterns Frequency Consistency

Doctor's Notes:



SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

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

Form with fields for Vigorous Exercise, Moderate Exercise, Alcohol Use, Drug Use, Tobacco Use, Caffeine Use, High Stress Activity, Family Pressures, Financial Pressures, Other Mental Stress, and Other (specify).

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

Table with 7 columns: CONDITION, FATHER, MOTHER, SPOUSE, BROTHER(S), SISTERS, CHILDREN. Rows list various conditions like Arthritis, Asthma, Diabetes, etc.

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

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

# INFORMED CONSENT



PATIENT NAME \_\_\_\_\_

CORE CHIROPRACTIC, LLC  
Kaile Myrick, D.C.  
4730 Centennial Blvd, Ste102  
Colorado Springs, CO 80919  
P (719) 599-8682

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination, tests, diagnostic x-rays which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named above.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had the opportunity to discuss with the doctor named above and /or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfactions. I understand that the results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of potential risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my recent condition and for any future conditions(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

DATE \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian (if a minor)