Hoglen Chiropractic & Laser

Patient Health History Form

Confidential

Date	Patient ID Number	Code

Patient Information

Name: _____

SS#: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Occupation: _____

Employer: _____

Spouse's Name: _____

Name(s) of Children: _____

Referred By: _____

Insurance

Do you have Insurance: ☐ Yes ☐ No

PRIMARY INSURANCE

Insurance Co.: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Relationship to patient: _____

Do you have a Secondary Insurance: ☐ Yes ☐ No

SECONDARY INSURANCE

Insurance Co.: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Relationship to patient: _____

Contact Information

Primary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Email Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name of Emergency Contact Person: _____ Relationship to Patient: _____

Primary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Secondary Phone: _____ ☐ Cellular/Mobile ☐ Home ☐ Work/Business

Current Health Condition

Primary Complaint: _____

When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No

Rate the Pain from 1 (least pain) to 10 (severe pain): _____ Does the condition occur: ☐ Daily ☐ Weekly ☐ Monthly

Is the persistance of this condition: ☐ Intermittent (0-25% of the time) ☐ Occasional (26-50% of the time) ☐ Frequent (51-75% of the time) ☐ Constant (76-100% of the time)

Please list other doctors you have seen for this condition: _____

Type of Treatment: _____

Is this condition related to: ☐ Work Accident ☐ Auto Accident ☐ Home Injury ☐ Stumble/Fall ☐ Other: _____

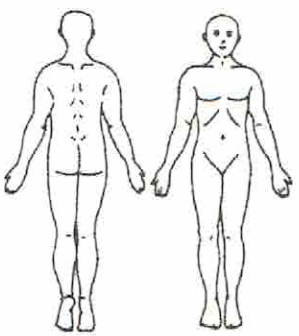
Date and Time of Accident: _____

Claims Filed: ☐ Auto Insurance ☐ Employer ☐ Workman's Comp. ☐ None

Please list all medications which you currently take: _____

Please list all Supplements which you currently take: _____

List any other health complaints (not listed above): _____



Please outline on the diagram the area of your discomfort

Past Health History Information

Please list any Surgery and/or Operations you have had: _____

_____

Please list all Accidents or Major Falls you have had: _____

_____

Please list any additional Hospitalization (other than above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____

Please Check the following based on your current lifestyle. Do You...

Smoke ☐ Yes ☐ No Packs/day: _____ Consume Caffeine ☐ Rarely ☐ Occasionaly ☐ Frequently

Drink Alcohol ☐ Yes ☐ No Drinks/week: _____ Exercise ☐ Rarely ☐ Occasionaly ☐ Frequently

Do your daily activities include: ☐ Lifting ☐ Bending ☐ Pulling ☐ Sitting ☐ Standing ☐ Heavy Labor ☐ None

Please Check ANY of the following diseases you have had:

☐ Pneumonia	☐ Anemia	☐ Diabetes	☐ Pleurisy	☐ Eczema
☐ Rheumatic Fever	☐ Measles	☐ Cancer	☐ Arthritis	
☐ Polio	☐ Mumps	☐ Heart Disease	☐ Epilepsy	Have you ever been
☐ Tuberculosis	☐ Small Pox	☐ Thyroid	☐ Mental Disorders	tested HIV Positive?
☐ Whooping Cough	☐ Chicken Pox	☐ Influenza	☐ Lumbago	☐ Yes ☐ No

Please Check ANY of the following conditions, if they have occurred in the past 6 months:

MUSCULO-SKELETAL
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm pain
- ☐ Joint Stiffness/Pain
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY
- ☐ Bladder Trouble
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Discolored Urine

GENERAL
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose

MALE/FEMALE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain or Lumps
- ☐ Prostate Problems
- ☐ Sexual Dysfunction
- ☐ Other: _____

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

FAMILY HISTORY

The following members have the same or a similar condition as me:
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

Authorization of Care

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.

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Complete Wellness Chiropractic Center wants me to know how my Patient Health Information is going to be used in this office and my rights concerning those records. I understand that if I would like to have a more detailed account of this office's policies and procedures concerning the privacy of my Patient Health Information, I may read the HIPAA Notice that is available to me at the front desk before signing this consent.

Patient's Signature: _____ Date: _____

Guardian's Signature of Authorizing Care: _____ Date: _____