Welcome to our office.

Date:___/___/____ Whom can we thank for referring you: ______________________

Patient Information

_______________________________________ ______-_____-________ ________ ____/_____/________
First, Middle, Last Name Social Security # Age Date of Birth

______________________________ _____________________ ________ ___________
Address City State Zip Code

___M ___F Nickname __________________________

__________________ ______________ _________________ ____________________
Home Phone # Work Phone # Mobile Phone # *Cell phone carrier

☐ **You may text my cell phone with reminders** **email address**____________________________________

Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed # of Children______ Spouse's name________________

____ M.D. _______-______- _________
Medical doctor Phone#

Employment Information

Employment Status: ☐Full Time ☐Part Time ☐ Student ☐ Retired or Disabled ☐ Unemployed

__________________________ ___________________________ ______________________
Occupation Employer/ Company Name Employers Phone #

______________________________ _______________________ _________ ______________
Address City State Zip Code

Relative to Contact in Case of Emergency (Not living in Home of Patient)

___________________________________ ___________________ ______________________
Name Phone # Relationship to Patient

___________________________________ ___________________ _________ ___________
Address City State Zip Code

*** If insurance card is not in your name fill out section below:**

Primary Insurance Card Holder: ☐Spouse ☐ Parent ☐ Other ______________

____ ______ -______- ________ ___/____/_____
First, Middle, Last Name Social Security # Date of birth

________________________________ _____________________ _________ _____________
Address City State Zip Code

_____________________ ___________________ __________________ ____________________
Home Phone # Work Phone # Mobile Phone # E-Mail

__________________ ________________________ ________________ ______ ___________
*Employer Employers Address City State Zip

Secondary Insurance Cardholder: Relationship to you______________________

____________________________________ _____-______-__________ ____/____/______ ________________
First, Middle, Last Social Security # Date of birth

_____________________________ _____________________ __________ ___________
Address City State Zip Code

______________ ____________ ____________ ____________________________
Home phone # Work phone # Mobile phone # E-mail address

________________ ________________________ ________________ ________ __________
Employer Employer's address City State Zip code

Name________________________________ Date____/____/_______

Assignment and Release of Primary Insurance Benefits

If you want benefits to be sent to Hanley Chiropractic HealthCare directly please read and then sign the following.

I, the undersigned certify that I (or my dependent) have insurance coverage with___________________________________ and assign directly to Hanley Chiropractic HealthCare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that all charges that are denied which may include any insurance, workers compensation and personal injury claims are my responsibility and are to be paid in full. I hereby authorized Hanley Chiropractic HealthCare to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

____ _________________ ____

Patient Signature or parent for minor Date Patient's relationship to cardholder

Consent to Treat and Financial Responsibility (<u>initial each section, sign, and date</u>)

_________ I voluntarily consent to receive Chiropractic healthcare services from Dr. Stuart D. Hanley D.C. or whomever he may designate as his assistants and/or associates to administer treatment, examinations as well as diagnostic and chiropractic procedures for spinal and/or extremity subluxation only.

_________ I fully understand and agree that all services rendered to me are directly my responsibility and that I am personally responsible for all charges due to Hanley Chiropractic HealthCare. I also understand that should my account fall delinquent that my account may be turned over for legal collection and reported to the credit bureau. In the event that my account is turned over for collection I agree to pay the cost of collection, including reasonable attorneys fees.

____ ___________________

Patient's Signature Date

If patient is under 18, parent or guardian must complete this portion.

Consent to Treat a Minor (if patient is under 18)

I (we) being the parent, guardian or custodian of the minor being_______________________________________, age _________, do hereby authorize, request and direct Dr. Stuart D. Hanley D.C. and whomever he designates as his assistants and/or associates to perform examinations, diagnostic procedures including x-rays, laboratory tests and any treatment that in their judgment is deemed advisable or required. It is the understanding of the undersigned that the doctor and their staff will have full authority from me as legal parent/guardian to continue with examinations diagnostic procedures and tests and treatments as will be needed while said minor showed above is under care in this office until legal age is obtained.

As legal parent/guardian I realize full responsibility for all charges and payments due.

____ _____________________ __________________________________

Parent, Guardian or Custodian Signature Date Witness

Name____________________________________ Date____/_____/_______

Name of Attorney, if auto accident or work-related: ____

ATTENTION: If question does not apply put N/A in the space.

Is your condition related to: ☐ work injury ☐ auto accident or personal injury

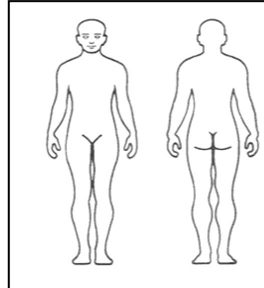
Complaints: Mark area of complaints on the figure to the right with an X also if pain radiates please mark where it radiates with arrow.

#1 problem ____

#2 problem ____

#3 problem ____

#4 problem ____



PAIN SCALE
Circle a # (1 Least-10 Most)

Neck _______________
1 2 3 4 5 6 7 8 9 10

Mid Back_______________
1 2 3 4 5 6 7 8 9 10

Low Back_______________
1 2 3 4 5 6 7 8 9 10

Arms _______________
1 2 3 4 5 6 7 8 9 10

Legs _______________
1 2 3 4 5 6 7 8 9 10

When did it start? (Approx. time or Date) ________/_________/___________

How and Where did the condition start (fall, strain, no apparent reason, etc.)____

Condition is: ☐ improving ☐ getting worse ☐ no change ☐ worse with movement

It feels: ☐ achy ☐ burning ☐dull ☐ sharp ☐ throbbing ☐ shooting ☐ cramping ☐ stabbing

Is it: ☐ mild ☐ moderate ☐ severe ☐ agonizing

Pain/condition is: ☐ constant ☐ frequent ☐ intermittent ☐ occasional

Does pain radiate or refer into another area? ☐ no ☐ yes, into my ____

Also have: ☐ decreased range of motion or movement ☐ numbness ☐ tingling ☐ spasms ☐ weakness ☐ swelling/inflammation

What makes condition better: ☐ nothing ☐ cold ☐ chiropractic care ☐ massage ☐ medication ☐ movement ☐ resting ☐ sleeping ☐ walking ☐ warmth

What makes condition worse: ☐ nothing ☐ driving ☐ lifting ☐ movement ☐ resting ☐ sleeping ☐ sitting ☐ standing ☐ walking ☐ working ☐ bending ☐ breathing

Headache is: ☐ none ☐ front of head ☐ side of head ☐ back of head ☐ morning ☐ as day progresses ☐ afternoon ☐ during the day ☐ evening ☐ upon awakening ☐ constant

Habits: ☐ **tobacco:** ________ x/day ☐ **tobacco** used in the past, but none now ☐ never used tobacco

☐ **alcohol:** ______ drinks/wk ☐ **Caffeinated coffee/tea /soda** _________ servings/day ☐ **artificial sweetener**

Please list all current drugs (prescription and OTC): ____

____

Surgeries/hospitalizations for : ❑spinal/joint ____________________________ ❑ cancer ________________________

❑ other ____

Past or present major illnesses ❑ none ❑pacemaker/heart ❑ diabetes ❑ stroke ❑ cancer (type) ___________________________

❑radiation ❑ chemotherapy ________ yrs/months ago ❑ treatment is ongoing ❑ spinal condition (scoliosis, congenital defect, etc.)

Recent tests (within 2 yrs. Body part and mo/yr): ☐ MRI ______________ ☐ C-T _______________☐ x-rays ______________________

Hanley Chiropractic HealthCare 955 Factory Road, Beavercreek, OH 45434 P# 937-426-4545 F#937-426-4548

Name_________________________________ Date_____/______/_____

History: Check if YOU have now or have had any of the following:

___Fractured bones ___Auto accidents ____0-1 yrs ago ____1-5 yrs ago ____ more than 5 years ago ___Other accidents/falls ___Knocked unconscious ___Back curvature ___Mental or emotional disorders ___Arthritis ___Diabetes ___Swollen or Painful joints ___Convulsions/Epilepsy ___Skin problems ___Itching ___Bruising ___Cancer ___Frequent Colds/Flu ___Nervous ___Tension ___Depressed ___Irritable ___Anemia ___Excessive Sweating ___Tremors ___Light bothers eyes ___Allergy ___Sinus Problems ___Lightheaded upon rising ___Under stress ___Crave Sweets or Salts ___Eating disorders ___Trouble Sleeping ___Trouble Concentrating	___Loss of Memory ___Learning Disability ___Mistake sidedness (R from L) ___Stutter ___Dyslexia ___Mood changes ___Lose temper easily ___Headache ___Neck pain or stiff R or L ___Numbness, tingling, or pain in arms, hands, fingers R or L ___Jaw pain or click/TMJ R or L ___Head seems too heavy ___Head and shoulders feel tired ___Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties) ___Shoulder pain R or L ___Dizziness ___Ringing in ears R or L ___Hearing loss R or L ___Fainting ___Loss of balance ___Blurred or double vision R or L ___Upper back pain or stiffness R or L ___Midback pain or stiffness R or L ___Lower back pain or stiffness R or L ___Numbness, tingling or pain in the buttocks, thighs, legs, feet, toes R or L ___Pain with cough, sneeze or strain at the stool ___Hip pain R or L ___Foot trouble R or L	___Chest pain ___Asthma ___Lung problems ___Difficulty breathing ___Wheezing ___Heart problems ___Stroke ___High or low blood pressure ___Varicose veins ___Liver trouble ___Gallbladder trouble ___Digestive problems ___Excess gas ___Belching/bloating after meals ___Heartburn ___Ulcers ___Diarrhea/constipation ___Colon trouble ___Hemorrhoids ___Prostate problems ___Impotence ___Kidney problems ___Kidney stones ___Frequent urination ___Discharge ___Menstrual problems/PMS ___Menopause problems ___Breast lumps, soreness, discharge ___Pregnant (now) ___Bedwetting ___Ear infections ___Hepatitis ___Venereal disease ___AIDS/HIV

Family History: F (father) M (mother) S (sibling) C (child) *Circle all that apply.*

☐ cancer : F M S C (name types) ____

☐ stroke F M S C ☐ heart attack F M S C ☐ diabetes F M S C ☐ depression F M S C

Most recent Chiropractic care(approx. date - mm/yy) **:** ______/_____ Dr. ______________________________ D.C.

Approximately how many Chiropractic visits have you had in your life: ____________

Work activities ☐ physical(factory,trade, lifting,etc.) ☐ sedentary(desk,computer,office,etc.) ☐ combination(some paperwork, some heavy lifting, etc.)

Current work status due to condition: ☐ none missed ☐ light-duty ☐occasionally missed ☐ working part-time ☐ have not returned to work ☐ returned to work but unable to continue ☐ off work then returned on_____/_____/_____ ☐ retired ☐ unemployed

Exercise (not work-related) ☐ none ☐ daily ☐ ______ x/wk ☐ never

Type ☐ cardio ☐ resistance/weights ☐ ______ yoga/pilates

Past treatment for <u>this</u> condition: ☐ none ☐ Chiropractic care ☐ over-the-counter medications ☐ physical therapy ☐ prescription medications ☐ cortisone injections ☐ surgery to area of concern ☐ massage

How long ago? ____ **Did it help?** ☐ yes ☐ no

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