Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Marital Status: ◯Yes ◯No Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ◯Yes ◯No Advertisement: _____

Referred Directory: ◯Yes ◯No Referred Directory: _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information

Payment: ◯Personal ◯3rd Party ◯Self Resp. for Payment: _____ Responsible Phone : _____

Payment Name: _____ Primary Phone #: _____ Primary ID/Policy: _____

Payment Address: _____

Payment City: _____ Payment State: _____ Payment Zip: _____

Primary Group #: _____ Primary Name: _____ Primary DOB: _____

Secondary Name: _____ Secondary Phone #: _____ Secondary ID/Policy: _____

Secondary Address: _____

Secondary City: _____ Secondary State: _____ Secondary Zip: _____

Secondary Group #: _____ Secondary Name: _____ Secondary DOB: _____

Claim #: _____ Claim Contact: _____ Claim Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

Complaint Information

Injury Occurred: ◯Automobile ◯Work ◯Third-Party ◯Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Frequency: ◯Always ◯Hourly ◯Daily ◯Occasionally

Interfere w/ Activities: ◯Yes ◯No Affected Sleep: ◯Yes ◯No

Missed Work: ◯Yes ◯No Unable to Work from: _____ Unable to Work til: _____

Affected Appetite: ◯Yes ◯No Explain: _____

Reduced Work: ◯Yes ◯No Explain: _____

Does it Worsen: ◯Yes ◯No Explain: _____

Weather Affects it: ◯Yes ◯No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯Yes ◯No Explain: _____

X-rays Taken: ◯Yes ◯No Explain: _____

Same Condition Before: ◯Yes ◯No Date: _____ Practitioner: _____

History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Surgeries/Hosp: _____

Previous Chiro Care: ◯Yes ◯No Date: _____ Explain: _____

Chance Pregnant: ◯Yes ◯No Planning: ◯Yes ◯No

Medications: _____

Supplements: _____

Broken Bones: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Sprains/Strains: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Hospitalized: ◯Yes ◯No Explain: _____

Surgery: ◯Yes ◯No Explain: _____

Auto Accident: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Struck Unconscious: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Eating Disorder: ◯Yes ◯No Explain: _____

Stroke: ◯Yes ◯No Explain: _____

Family Health Hist: _____

Patient Social

Alcohol:	◯Daily	◯Weekly	◯Occasion	◯Never	Caffeine:	◯Daily	◯Weekly	◯Occasion	◯Never
Diet Food Products:	◯Daily	◯Weekly	◯Occasion	◯Never	Drugs:	◯Daily	◯Weekly	◯Occasion	◯Never
OTC Stimulants:	◯Daily	◯Weekly	◯Occasion	◯Never	Exercise:	◯Daily	◯Weekly	◯Occasion	◯Never
Homemade Food:	◯Daily	◯Weekly	◯Occasion	◯Never	Processed Food:	◯Daily	◯Weekly	◯Occasion	◯Never
Soft Drinks:	◯Daily	◯Weekly	◯Occasion	◯Never	Tobacco:	◯Daily	◯Weekly	◯Occasion	◯Never
Water:	◯Daily	◯Weekly	◯Occasion	◯Never					

Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	☐ Venereal Disease
☐ Other: _____		

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to The Chiropractic Wellness of Hudson, Inc all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

The Chiropractic Wellness Center of Hudson

5111 Darrow Road Hudson, OH 44236
(330)656-1977 (330)688-5988
www.thehudsonchiropractor.com

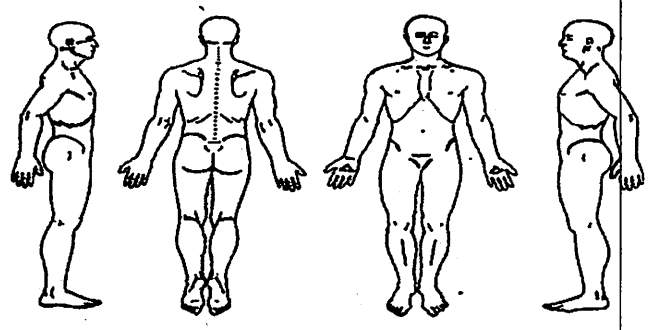
CASE HISTORY

Name: _____ Date: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____
    _____
18. Any other Musculoskeletal problems? ____No ____Yes ...Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____