



Patient Information

Date: _____	SSN: _____	Birthday: _____
First Name: _____	Middle Name: _____	Last Name: _____
Sex: <input type="radio"/> M <input type="radio"/> F	Height: _____	Weight: _____
Marital Status: <input type="radio"/> Yes <input type="radio"/> 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: <input type="radio"/> Yes <input type="radio"/> No	Advertisement: _____	
Referred Directory: <input type="radio"/> Yes <input type="radio"/> No	Referred Directory: _____	

Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> Unemployed	Employer Name: _____	
Employer Address: _____		
Employer City: _____	Employer State: _____	Employer Zip: _____
Occupation: _____	Work Supervisor: _____	Supervisor #: _____
Work Duties: _____		

Insurance Information

Payment: <input type="radio"/> Personal <input type="radio"/> 3rd Party <input type="radio"/> 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:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	<input type="radio"/> Other	Injury Date: _____
Injury Origin:	_____				
Desc Discomfort:	_____				
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally	
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:	_____	Unable to Work til: _____
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Aggravates Condition:	_____				
Improves Condition:	_____				
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
X-rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____	
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Practitioner: _____

History

Last Physical Exam: _____	Primary Phys: _____	Phys Phone #: _____
Phys City: _____	Phys State: _____	Phys Zip: _____
Health Conditions:	_____	
Surgeries/Hosp:	_____	
Previous Chiro Care:	<input type="radio"/> Yes	<input type="radio"/> No
Date:	_____	Explain: _____
Chance Pregnant:	<input type="radio"/> Yes	<input type="radio"/> No
Planning:	<input type="radio"/> Yes	<input type="radio"/> No
Medications:	_____	
Supplements:	_____	
Broken Bones:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Sprains/Strains:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Hospitalized:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Surgery:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Auto Accident:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Struck Unconscious:	<input type="radio"/> Yes	<input type="radio"/> No
Treatment:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Eating Disorder:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Stroke:	<input type="radio"/> Yes	<input type="radio"/> No
Explain:	_____	
Family Health Hist:	_____	

Patient Social

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Caffeine:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Diet Food Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
OTC Stimulants:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Homemade Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Processed Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never					

Health Checklist

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

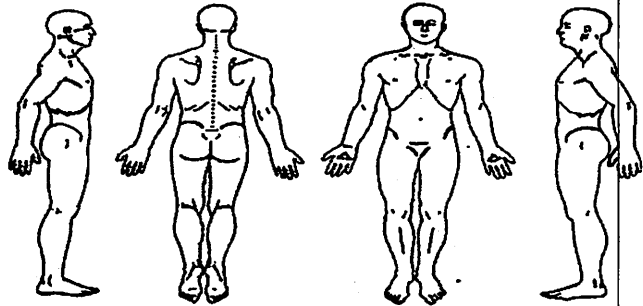
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					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: _____