HANSON FAMILY CHIROPRACTIC

PATIENT HEALTH ASSESSMENT AND APPLICATION FOR TREATMENT

WELCOME TO OUR OFFICE - PLEASE PRINT OR WRITE CLEARLY

PATIENT NAME			DATE	
PATIENT ADDRESS		CITY	STATE	ZIP
SEX M F	DATE OF BIRTH	AGE	SS#	
HOME PHONE	WORK PHONE	MOBILE PHONE	PREFERRED NUMBER	
EMAIL		REFERRED BY		
PRIMARY CARE PHYSICIAN	ADDRESS		PHONE	
PATIENT EMPLOYER		PATIENT OCCUPATION		
SUBSCRIBER NAME		RELATION TO PATIENT		
SUBSCRIBER EMPLOYER		SUBSCRIBER'S SS#		
HEALTH INSURANCE PLAN		GROUP #	MEMBER#	

COMPLAINT HISTORY

DOCTOR USE ONLY

DESCRIBE YOUR CURRENT COMPAINT AND HOW THE PROBLEM BEGAN:

HOW LONG HAVE YOU HAD THIS CONDITION? | DATE OF ONSET

HOW DO YOU DESCRIBE THE PAIN?

☐sharp ☐spasm ☐soreness ☐burning ☐throbbing ☐ache
☐tingling ☐weakness ☐dull ☐numbness ☐stiffness ☐shooting

CIRCLE THE INTENSITY OF YOUR PAIN. 0 = No Pain; 5 = Moderate Pain; 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

HOW OFTEN IS YOUR PAIN PRESENT?

☐Intermittent (25% or less) ☐Occasional (26-50%) ☐Frequent (51-80%) ☐Constant (81-100%)

HOW MUCH DOES YOUR PAIN INTERFERE WITH YOUR DAILY ACTIVITES? 1 = Mild Interference; 10 = Unable To Do

1 2 3 4 5 6 7 8 9 10

SINCE THE PROBLEM BEGAN IS YOUR PAIN:
☐getting worse ☐getting better ☐staying the same

HOW DID YOUR PROBLEM BEGIN?
☐gradual ☐sudden ☐car accident ☐work ☐other

WHAT MAKES YOUR PROBLEM BETTER?
☐nothing ☐walking ☐standing ☐sitting ☐laying down ☐movement ☐inactivity

WHAT MAKES YOUR PROBLEM WORSE?
☐nothing ☐walking ☐standing ☐sitting ☐laying down ☐movement ☐inactivity

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

HAVE YOU PREVIOUSLY HAD TREATMENT FOR THIS SAME CONDITION?
☐Yes ☐No If yes, please describe: ☐MD ☐Chiropractor (DC) ☐Physical Therapy (PT) ☐Other

WHAT WERE THE APPROXIMATE DATES, TYPES OF TREATMENT, AND THE RESULTS?

WHAT IS YOUR DAILY PHYSICAL ACTIVITY?
☐mostly sitting ☐light office ☐light manual labor ☐moderate manual labor ☐heavy manual labor

DO YOU EXERCISE?
☐No ☐1-2 times per week ☐3-4 times per week ☐5-7 times per week

TYPE OF EXERCISE:
☐Cardiovascular ☐Strengthening ☐Yoga/Stretching ☐Types of Sports:

WHAT IS YOUR PRESENT GENERAL STRESS LEVEL?
☐None ☐Minimal ☐Moderate ☐Greatly Stressed

IS YOUR CURRENT CONTITION AFFECTING YOUR ABILITY TO WORK OR DO ROUTINE DAILY ACTIVITES?
☐Yes ☐No If yes, describe:

Over, please ➔

PAST OR PRESENT SYMPTOMS, CONDITIONS, OR HABITS

IF APPLICABLE, PLEASE CHECK THE BOX INDICATING WHETHER THESE SYMPTOMS, CONDTIONS, OR HABITS APPLY TO THE PAST OR PRESENT

CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION	PAST	PRESENT
Neck Pain	☐	☐	Stroke	☐	☐	Respiratory	☐	☐	Stiffness	☐	☐
Hand Pain	☐	☐	Diabetes	☐	☐	Bladder	☐	☐	Fainting	☐	☐
Hip Pain	☐	☐	Ovaries	☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐
Foot Pain	☐	☐	Shoulder Pain	☐	☐	Skin Condition	☐	☐	Digestive	☐	☐
Headaches	☐	☐	Upper Back Pain	☐	☐	Prostate	☐	☐	Sinus	☐	☐
Convulsions	☐	☐	Knee Pain	☐	☐	Menstrual	☐	☐	Cancer	☐	☐
Heart Condition	☐	☐	Jaw Pain	☐	☐	Arm Pain	☐	☐	Arthritis	☐	☐
Kidney	☐	☐	Dizziness	☐	☐	Lower Back Pain	☐	☐	Uterus	☐	☐
Allergies	☐	☐	Fatigue	☐	☐	Ankle Pain	☐	☐	Breast Soreness	☐	☐

HABITS	PAST	PRESENT	OCCASIONAL	MODERATE	HEAVY	CONDITIONS	PAST	PRESENT	
Tobacco	☐	☐	☐	☐	☐	Pregnancy	☐	☐	Due Date:__________
Alcohol	☐	☐	☐	☐	☐				
Caffeine	☐	☐	☐	☐	☐	Surgeries	☐	☐	Please list: ____________________

PLEASE INDICATE IF A CLOSE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING DISEASES

Adopted ☐

	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER
Alcoholism	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Kidney	☐	☐	☐	☐	☐	☐
Liver	☐	☐	☐	☐	☐	☐
Other:__________	☐	☐	☐	☐	☐	☐

MY ATTITUDE TOWARDS BEING HERE IS:

- ☐ Hopeful and Interested
- ☐ Fearful
- ☐ Skeptical
- ☐ Other:______________________________

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly and mutual understanding between provider and patient.

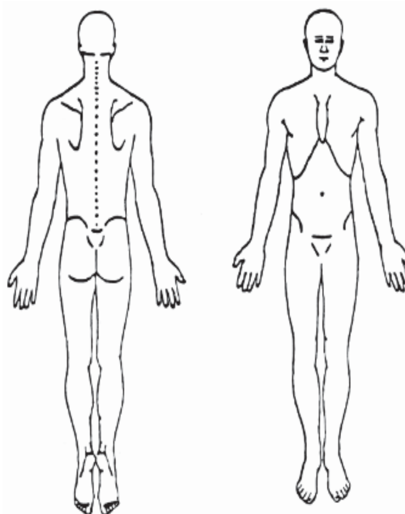
I authorize the Hanson Family Chiropractic staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or insurance company to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

Signature:______________________________

Date:______________________________

PLEASE SHADE IN THE AREA WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DOCTOR USE ONLY

I have reviewed the information contained on this form with the patient.

Provider Initials:__________ Date:__________

Patient Goals

1. ______________________________
2. ______________________________
3. ______________________________