HAELY
FAMILY CHIROPRACTIC

Patient History

TODAY'S DATE_____/_____/_____

PERSONAL INFORMATION

Patient Name: _____ Birthdate: _____/_____/_____

Age: _____ Male / Female (circle) SSN: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Children?: Yes / No How Many?: _____

Please Circle: Minor ▪ Married ▪ Divorced ▪ Separated ▪ Widowed

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____ How Long? _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Ins. Company Name: _____ Phone #_____

Address: _____ City: _____ State: _____ Zip: _____

Insured's ID#:_____ Group # (Plan, Local, Policy #)_____

Insured's Name: _____ Relation: (circle) SELF / SPOUSE / PARENT / OTHER

Insured's Date of Birth _____/_____/_____ Insured's Employer_____

Secondary Ins. Company Name: _____ Phone #_____

Address: _____ City: _____ State: _____ Zip: _____

Insured's ID#:_____ Group # (Plan, Local, Policy #)_____

Insured's Name: _____ Relation: (circle) SELF / SPOUSE / PARENT / OTHER

EMERGENCY INFORMATION – Who to call in case of emergency

Name:_____ Relation:_____ Cell Phone: _____

Home Phone:_____ Work Phone: _____

Your Medical Doctor:_____ Dr.'s Phone:_____

7500 Town Centre Dr. #300, Broadview Hts., OH 441147 ▪ 440.838.5755

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REASON FOR VISIT

The reason for this visit is a result of: (circle any that apply):

WORK • SPORTS • AUTO • TRAUMA • CHRONIC • OTHER _____

Explain what happened: _____

Please describe your pain and its location: _____

_____

When did condition begin?: _____ Is it getting worse?: Yes • No • Constant • Comes and Goes

Does it interfere with?: WORK • SLEEP • DAILY ROUTINE • Explain: _____

Have you had similar conditions in the past?: _____ Explain: _____

Have you been treated by anyone else for this condition? _____ If so, where, who and what was the treatment: _____

_____

Have you ever been treated by a chiropractor before?: YES • NO

If so, by whom? _____ Are you familiar with the Health Healing System? YES • NO

What stage are you in, if you know? RELIEF • RESTORATION • REVITALIZATION • PRAKTIKOS

HEALTH HISTORY

Are you taking any of the following medications? Circle all that apply.

Nerve Pills • Blood Thinners • Pain Killers • Aspirin • Tranquilizers • Muscle Relaxers • Insulin • Stimulants • Anti-Depressants • Cholesterol Meds • Birth Control • Other _____

Do you have or have you ever had any of the following? Circle all that apply.

Heart Attack • Mitral Valve Prolapse • Hepatitis • Frequent Neck Pain • Psychiatric Problems • Ulcers/Colitis • Diabetes • Tuberculosis • Artificial Bones/Joints • Heart Surgery/Pacemaker • Artificial Valves • HIV+/AIDS • Emphysema • Glaucoma • Rheumatic Fever • Fainting/Seizures/Epilepsy • Difficulty Breathing • Arthritis • Heart Murmur • Alcohol/Drug Abuse • Shingles • Anemia • Sinus Issues • Frequent Headaches • Cancer • Chemotherapy • Congenital Heart Defect • Venereal Disease • Asthma • High/Low Blood Pressure • Kidney Problems • Lower Back Problems • Sleeping Issues

Please list any other medical conditions you've had or have: _____

_____

_____

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FAMILY HISTORY							
Please indicate which conditions exist or have existed by marking the boxes below.							
	Self	Mother	Father	Sister	Brother	Son	Daughter
Bone Cancer	☐	☐	☐	☐	☐	☐	☐
Brain Cancer	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐	☐
Gastric Cancer	☐	☐	☐	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐	☐	☐	☐
Liver Cancer	☐	☐	☐	☐	☐	☐	☐
Muscle Cancer	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐
Rectal Cancer	☐	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
Deep Vein Thrombosis	☐	☐	☐	☐	☐	☐	☐
Pulmonary Embolism	☐	☐	☐	☐	☐	☐	☐
Unknown Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Gestational Diabetes	☐	☐	☐	☐	☐	☐	☐
Impaired Fasting Glucose	☐	☐	☐	☐	☐	☐	☐
Insulin Resistance	☐	☐	☐	☐	☐	☐	☐
Maturity Onset Diabetes (MODY)	☐	☐	☐	☐	☐	☐	☐
Pre-Diabetes	☐	☐	☐	☐	☐	☐	☐
Type 1 Diabetes	☐	☐	☐	☐	☐	☐	☐
Type 2 Diabetes	☐	☐	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐	☐
Familial Adenomatous Polyposis (FAP)	☐	☐	☐	☐	☐	☐	☐
Gastrointestinal Disorder	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐
Lynch Syndrome	☐	☐	☐	☐	☐	☐	☐
Angina	☐	☐	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐	☐	☐

	Self	Mother	Father	Sister	Brother	Son	Daughter
Heart Attack	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Unknown Heart Disease	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Cystic Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Chronic Kidney Disease (assoc. Diabetes Type 2)	☐	☐	☐	☐	☐	☐	☐
Congenital Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Kidney Nephrosis	☐	☐	☐	☐	☐	☐	☐
Nephritis	☐	☐	☐	☐	☐	☐	☐
Nephrotic Syndrome	☐	☐	☐	☐	☐	☐	☐
Other Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Unknown Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	☐	☐	☐	☐
Chronic Lower Respiratory Disease	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐
Influenza	☐	☐	☐	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐	☐	☐
Panic Disorder	☐	☐	☐	☐	☐	☐	☐
Personality Disorder	☐	☐	☐	☐	☐	☐	☐
PTSD	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Social Phobia	☐	☐	☐	☐	☐	☐	☐
Septicemia	☐	☐	☐	☐	☐	☐	☐
Stroke/Brain Attack	☐	☐	☐	☐	☐	☐	☐
Sudden Infant Death Syndrome	☐	☐	☐	☐	☐	☐	☐

PLEASE SELECT ALL THAT APPLY TO YOU							
Asthma	☐	Back Pain	☐	Bladder Trouble	☐	Bone Fracture	☐
Cancer	☐	Chest Pain	☐	Concussion	☐	Constipation	☐
Convulsions	☐	Depression	☐	Diarrhea	☐	Dislocated Joints	☐
Epilepsy	☐	Fibromyalgia	☐	German Measles	☐	Headache	☐
Heart Trouble	☐	Hepatitis	☐	Kidney Disorder	☐	High Blood Pressure	☐
High Cholesterol	☐	HIV/AIDS	☐	Migraine Headaches	☐	Loss of Bowel Control	☐
Lung Disease	☐	Menstrual Cramps	☐	Nervousness	☐	Multiple Sclerosis	☐
Muscular Dystrophy	☐	Neck Pain	☐	Pinched Nerve	☐	Numbness	☐
Osteoporosis	☐	Parkinson's Disease	☐	Rheumatic Fever	☐	Polio	☐
Poor Circulation	☐	Reproductive Disorder	☐	Scoliosis	☐	Rheumatism	☐
Rheumatiod Arthritis	☐	Scarlet Fever	☐	Thyroid Problems	☐	Serious Injury	☐
Sinus Trouble	☐	Stroke	☐	Venereal Disease	☐	Tuberculosis	☐
Tumors/Growths	☐	Ulcers	☐	Herniated Disk	☐		☐

HAELY

Patient History

Allergies: _____

Previous Surgeries/Treatments with Dates: _____

_____

Past Accidents with Dates: _____

Family Health History: _____

_____

Do you take supplements/vitamins? YES ▪ NO Exercise? YES ▪ NO Frequency? _____

Are you on a special diet? YES ▪ NO If yes, what kind? _____ Since:? _____

Do you smoke? YES ▪ NO How much? _____ How long? _____

Do you wear?: Heel lifts ▪ Sole lifts ▪ Inner Soles ▪ Arch Supports

How old is your mattress? _____ yrs. Is it comfortable? YES ▪ NO

Are you pregnant? YES ▪ NO How far along? _____ Nursing? YES ▪ NO

PLEASE READ AND SIGN BELOW:

- ☐ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- ☐ I agree to payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. If my account is 90 days past due, and no arrangements have been made, I understand that my account will be sent to collections/legal.
- ☐ I authorize the staff to perform any necessary services during diagnosis and treatment. I also authorize the doctor and insurance company to release any information 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 the office of any changes to the information I have provided.

Signature _____ Date: _____

Initial here if parent or guardian_____

One more page – you're almost done!

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HAELY

Patient History

Today's Date: _____ **PAIN CHART**

Name: _____ Current Weight: _____ Height: _____ft. _____in.

Please describe your condition: _____

_____

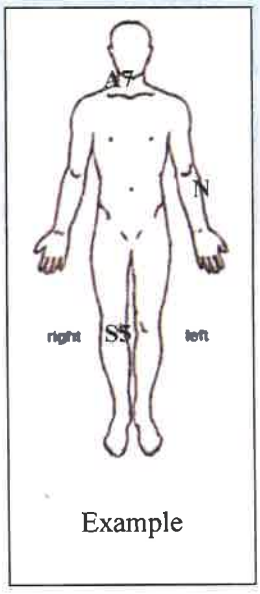
Signature: _____ Date: _____

SHOW US WHERE IT HURTS!

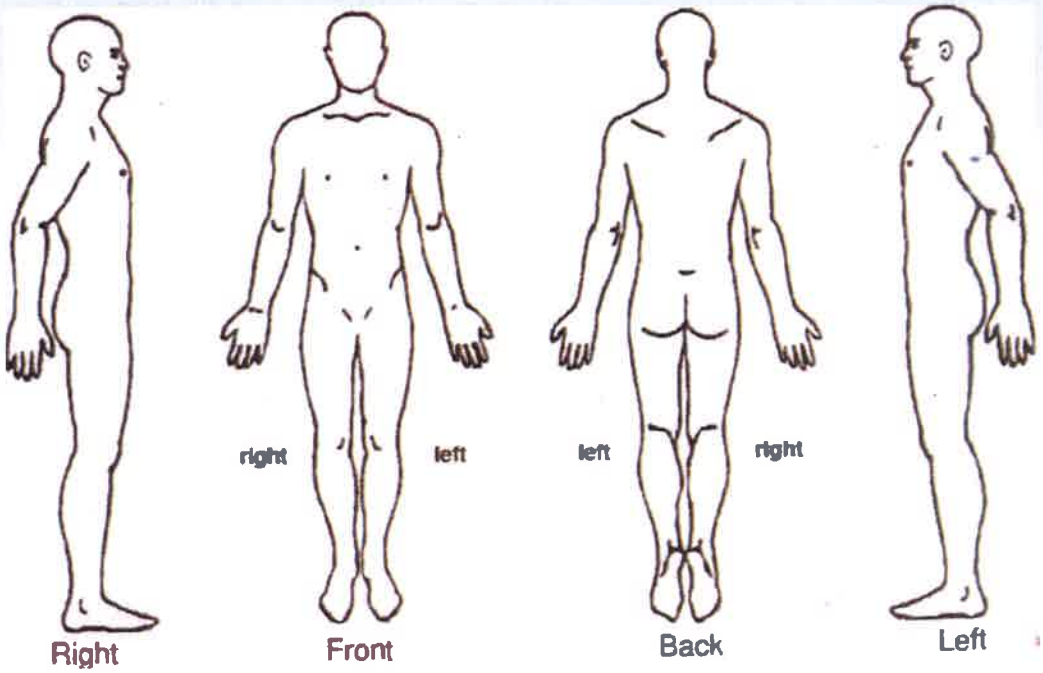
Please mark area(s) of injury or discomfort as shown below. Mark all areas with appropriate symbols. Then, indicate the level of pain, using the **1 to 10 pain scale**, where **10 is the worst** pain you've ever had, and **1 is very little pain.**

SYMBOLS TO USE:

Numbness – N Pins & Needles – P Burning – B
Aching – A Stabbing – S



Example



Right Front Back Left

Describe any other symptoms here:

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