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 ▪ Single ▪ Married ▪ Divorced ▪ Separated ▪ Widowed
Race/Ethnicity: (circle any that apply) Caucasian ▪ African American ▪ Hispanic ▪ Asian ▪
Other _____ ▪ Prefer No Response
Do you smoke? YES ▪ NO How much? _____ How long? _____

Preferred Language: _____

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:_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

5171 Wallings Road, Suite 120, N. Royalton, OH, 44133 ▪ 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

Medication	Dosage	# Times Taken Per day	Start Date	Prescribing Doctor

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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Allergies (Meds, Foods, Pollen, etc.): _____

_____

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 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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TODAY'S DATE_____/_____/_____

Today's Date: _____

PAIN CHART

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

Please describe your condition:_____

_____

Signature:_____ Date: _____

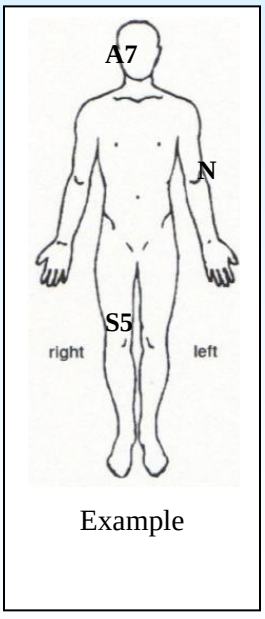
SHOW US WHERE IT HURTS!

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**.

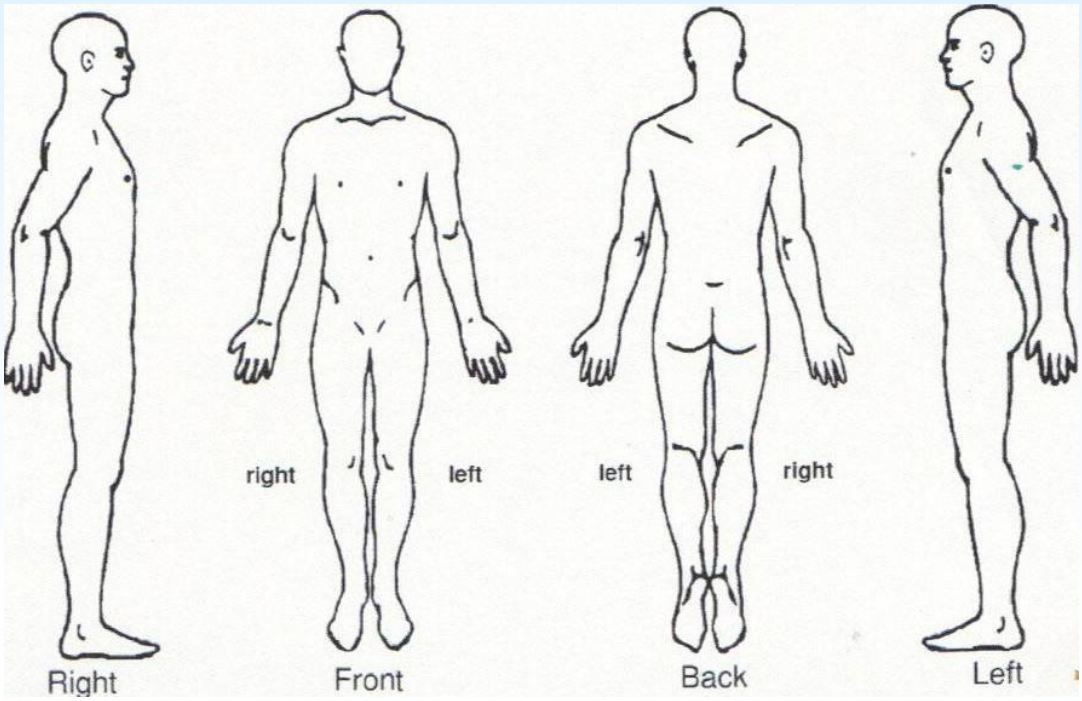
SYMBOLS TO USE:

Numbness – N Pins & Needles – P Burning – B

Aching – A Stabbing – S



Example



Describe any other symptoms here:

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