Patient History

TODAY'S DATE_____/_____/_______

PERSONAL INFORMATION

Patient Legal Name: ______________________________________ Preferred Name: ________________________

Birthdate: _______/__________/_________ Age: _______ Male / Female / Non-binary (circle one)

Home Address: ___________________________________ City: ___________________ State: _____ Zip: __________

Home Phone: ____________________ Work Phone: _______________________ Cell Phone: __________________

Email: ____ Children?: Yes / No How Many?: ________

Please Circle: Minor ▪ Single ▪ Married/Partner ▪ Divorced ▪ Separated ▪ Widowed
Do you smoke? YES ▪ NO How much? __________________________ How long? ________________________

Emergency Contact Name: ________________________Emergency Contact Phone: _________________________

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

HAELY FAMILY CHIROPRACTIC

Patient History

TODAY'S DATE_____/_____/______

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 ▪ 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 ▪ Sleeping Issues ▪ Very High Stress ▪ Depression ▪ Anxiety ▪ Psychiatric Problems ▪ Frequent Neck Pain ▪ Lower Back Problems ▪ Knee Pain ▪ Difficulty Walking / Standing / Sitting (circle any that apply)

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

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HAELY FAMILY CHIROPRACTIC

Patient History

TODAY'S DATE_____/_____/_______

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

____

Previous Surgeries/Treatments with Dates:____

____

Past Accidents with Dates: ____

Family Health History Concerns: ____

____

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: _________________

PAIN CHART

Name: ____________________________ Current Weight: ________ Height: ________ft. ________in.

Please describe your condition:____

____

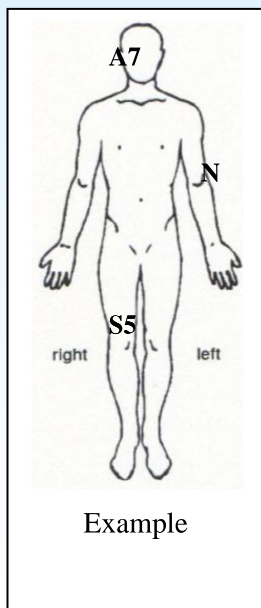
Signature:____ Date: ____________________________

SHOW US WHERE IT HURTS!

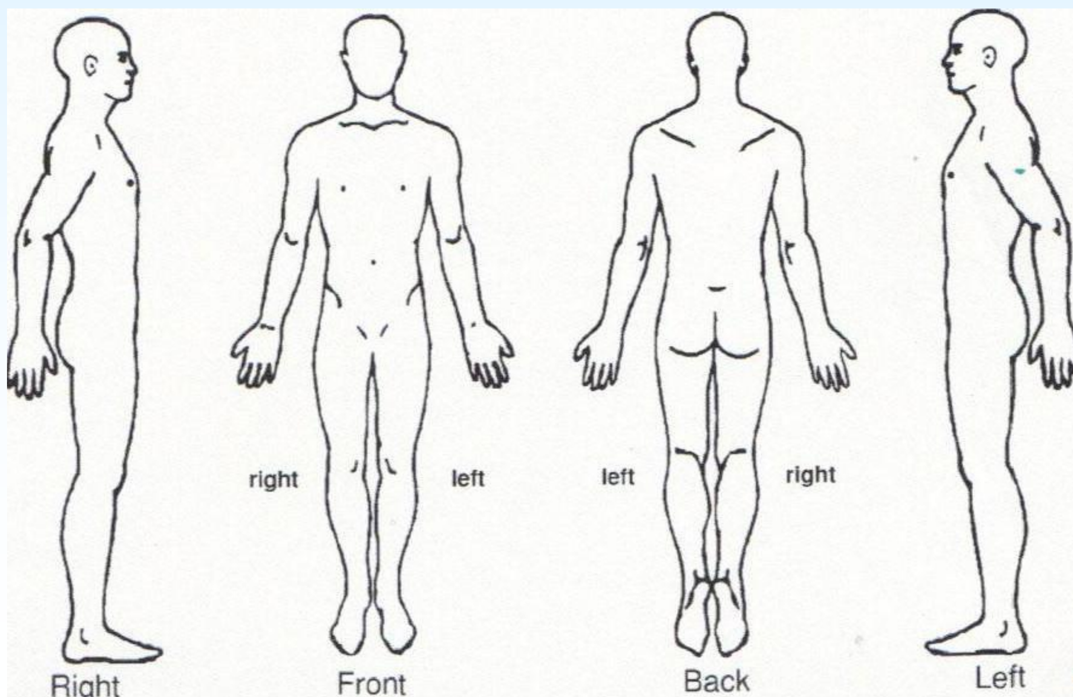
Please mark area(s) of injury or discomfort as shown below. Mark all areas with appropriate symbols. Then, indicate the level of pain, using the **1 to 10 pain scale**, where **10 is the worst** pain you've ever had, and **1 is very little pain**.

SYMBOLS TO USE:

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



Example



Describe any other symptoms here:

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