Confidential Patient Information

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status (circle one) M S D W

Sex: M F Age: _____ E-mail Address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office? _____

Is this injury/illness related to an Automobile Accident? Yes ☐ No ☐

Have you ever had Chiropractic care before? Yes ☐ No ☐ Date: _____

Due to changes in health insurance fees, patient self billing has become a much more cost-effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low, so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

Please mark ***one* option below which best describes your health goals.**

☐**Corrective Care:** I want to find the cause of the problem and correct it as much as possible.

☐**Performance/Relief Care:** I want to reduce or eliminate specific symptoms as quickly as possible.

☐**Wellness Care:** I don't have any specific symptoms or problems that I know of. I just want to make sure my body is functioning at its best.

☐**Occasional Treatments:** I like the way I feel after getting an adjustment and/or ART treatment and want to have a chiropractic office I can go to when I need treatment.
How frequently do you like to get adjusted/ART? _____ times per week / month / year?

☐**Other:** _____

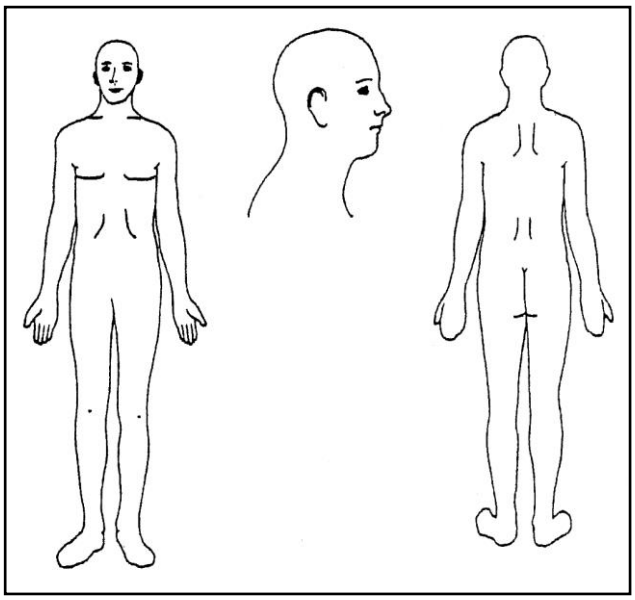
I authorize Hannah Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

THANK YOU FOR ALLOWING US TO SERVE YOU!

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the past 12 months:

( ) Headaches ( ) Migraines
( ) Numbness
( ) Sinus Congestion / Allergies
( ) Vision Problems
( ) Ear Aches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems / Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/ Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Trouble walking / sitting / standing

How often _____
( ) Tightness _____
( ) Frequent Nausea / Vomiting
( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful / Excessive Urine
( ) Discolored Urine
( ) Diabetes
( ) Weakness
( ) Cancer _____

For Women only: Are you pregnant? ( ) Yes ( ) No ( ) Not Sure