

Patient Information Sheet

Hanson Chiropractic Clinic

PO Box 555 306 N Mill Street
Fertile, MN 56540 218-945-3220

Patient **Date** ____/____/____
Last Name _____ First Name _____ Middle Initial ____
Gender: M F Date of Birth ____/____/____ Age ____ SSN _____ Marital Status: M S D W
Home Address _____ E-Mail _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer Name _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____

Spouse or Guardian (if responsible for health insurance)

Last Name _____ First Name _____ Middle Initial ____
Relationship to Patient _____ Phone _____
Address _____ City _____ Zip _____
Employer Name _____ Work Phone _____
Date of Birth ____/____/____ Cell Phone _____

Referred By: Family /Friend (Please state name) _____ Other _____

Insurance: Blue Cross Worker's Comp Medicare Auto MA Group Ins Self Pay
*Please present your insurance card(s) for photocopying

Race

___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Hispanic or Latino ___ White
___ Native Hawaiian or Pacific Islander ___ Some other race ___ Multi-racial

Ethnicity ___ Not hispanic or Latino ___ Hispanic or Latino

Preferred Language ___ English ___ Spanish ___ Other(please list) _____

PERSONAL HISTORY

- 1. What is your chief complaint today?: _____
 - a. When did your symptoms start? _____
 - b. What caused your symptoms to begin? _____
- 2. How often do you experience your symptoms?
___ Constantly (76- 100% of the day)
___ Frequently (51- 75% of the day)
___ Occasionally (26-50% of the day)
___ Intermittently (0- 25% of the day)
- 3. What describes the nature of your symptoms?
___ sharp ___ shooting ___ stiff/sore
___ dull ache ___ burning ___ throbbing
___ numb ___ tingling ___ tense/tight
- 4. How are your symptoms changing?
___ getting better ___ not changing ___ getting worse
What makes your symptoms worse? _____
What makes your symptoms better? _____
- 5. Circle the lowest and highest levels of your symptoms? None Unbearable
0 1 2 3 4 5 6 7 8 9 10
- 6. In general, would you say your overall health right now is.....
___ excellent ___ very good ___ good ___ fair ___ poor

7. a. Are you pregnant? Yes No not sure
 b. Are you currently on any medications or supplements? List them please.

 c. Do you smoke? Y N Previously
 d. Allergies: Environmental? _____
 Medications? _____
 Food? _____
 e. Do you drink alcohol, coffee, or pop? (If so, what and how many/day?) _____
8. Have you previously seen a chiropractor? Y N If yes, who and where? _____
7. Who have you seen for these symptoms?
 ___no one ___chiropractor ___medical doctor ___physical therapist ___other
 What treatment did you receive and when? _____
9. Have you had similar symptoms in the past? Y N
 If you received treatment in the past for similar symptoms, who did you see?
 ___this office ___other chiropractor ___medical doctor ___physical therapist ___other
10. Do you have any other health problems such as
 ___heart or blood pressure problems ___gastrointestinal problems ___organ(liver,kidney, etc) problems
 ___urinary ___muscleskeletal ___arthritis
 ___eye, ear, nose, throat, ___respiratory/lungs ___other health concerns/problems
- If you checked any of these, please explain: _____

11. In the last 6 months:
 a. Have you lost or gained more than 5 lbs? Y N If so how much? _____
 b. Have you had any unusual bleeding? Y N If so, please explain. _____
 c. Have you been feeling unusually fatigued? Y N

12. Do you have family members that have any of the following health concerns? Please indicate which family member.(i.e.-Mom, Dad, Sister, Brother, Grandmother, Grandfather)

Arthritis _____ Osteoporosis _____
 Back Problems _____ What kind of problem? _____
 High blood pressure _____ Heart Attack _____ Stroke _____
 Cancer _____ What kind of cancer? _____
 Diabetes _____ Other _____

13. Type of care desired: _____Corrective _____Symptom Relief
Signature: (Patient, Parent, Legal Guardian, or Responsible Party)

I request services: _____ Date _____

The above signature means that I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable.