Patient Information Sheet

Hanson Chiropractic Clinic
306 N Mill St
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

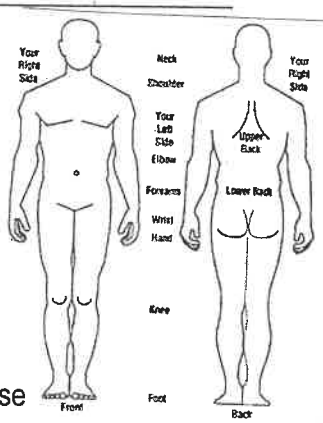
___American Indian or Alaska Native ___Asian ___Black or African American ___Hispanic or Latino ___White
___Native Hawaiian or Pacific Islander ___Some other race ___Multi-racial

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 symtoms?
   ____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? _____

None Unbearable
5. Circle the lowest and highest levels of your symptoms? 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.