Patient Information

Date: _____

Name_____Preferred Name_____ How did you hear about us?_____

SSN___XXXXXXXXXXXXX_____ Date of Birth_____ Age_____ Gender: M F

Address_____City_____State_____Zip_____Marital Status_____

Home or Cell Phone_____Email_____# Children_____

Occupation_____Employer_____Work Phone_____

Spouse's Name_____Parent's Names (if you are under 18) _____

My goal for consulting with the Dr: □ Temporary Relief □ Lasting Correction □Let Dr. recommend best type of care

Describe your major complaint:

_____

_____

Timing: Worse in the A.M._____ Worse in the P.M._____

When did your symptoms begin?_____ **Have you had similar symptoms in the past**? □Yes □No

How did your symptoms begin? _____

If your complaint is from an auto, work-related or personal injury, please see the office manager.

Progression (circle): Improving Not-Improving Worsening **What makes it worse?** _____

Describe: Sharp Shooting Achy Burning Numb Tingling **What makes it better?** _____

How severe are the symptoms on a scale of 1-10? (Circle) 1 2 3 4 5 6 7 8 9 10-WORST

In general, how would you rate your current overall health? Excellent Very Good Good Fair Poor

How has your major complaint affected your everyday activities?

□Not at all □Mildly affected □Slightly affected □Moderately affected □Severely affected

Have you missed school/work? No Yes How many days? _____

What activities are difficult for you to do now? _____

What are your favorite hobbies or activities?_____**Currently Affected?** Yes No

Have you received prior treatment for your main complaint? Y N if yes, with whom and what type of treatment was prescribed? _____

Have you seen a Chiropractor in the Past? Y N if yes, when was your most recent visit?_____

Why did you see the Chiropractor?_____Doctor's Name?_____

What frequency was prescribed for your care? _____

Do you have a recent set of spinal x-rays? _____

Have you had any MRI's or CT scans? Y N If yes, when and where? _____

Are you currently using/wearing foot orthotics? If so, are they custom made and fit to your feet? Y N

Who is your Primary Medical Physician? _____Clinic name/Phone_____

When was your last set of medical blood or urine tests?_____

HEALTH HISTORY - Please read through the list and check the box next to each condition that applies to you.

Last known: Height_____ **Weight**_____ **Blood Pressure** _____/_____**(don't know)**
Do you have an exercise routine? If so, please explain_____

Musculoskeletal - General
Now Past
- ☐ ☐ Degenerative arthritis
- ☐ ☐ Rheumatoid arthritis or Gout
- ☐ ☐ Compression fracture
- ☐ ☐ Osteomyelitis
- ☐ ☐ Osteoporosis

Musculoskeletal Spine
Now Past
- ☐ ☐ Poor Posture
- ☐ ☐ Disc injury
- ☐ ☐ Neck problem
- ☐ ☐ Mid-back problem
- ☐ ☐ Low back problem
- ☐ ☐ Scoliosis
- ☐ ☐ Ankylosing spondylitis
- ☐ ☐ Difficulty swallowing because of neck pain
- ☐ ☐ Pain or electric shocks in arms or legs on moving neck

Musculoskeletal Extremity
Now Past
- ☐ ☐ Hip or sacroiliac problem L R
- ☐ ☐ Leg, Knee, ankle or foot L R problem
- ☐ ☐ Shoulder problem L R
- ☐ ☐ Arm,elbow,hand problem L R
- ☐ ☐ Rib or chest pain

Nervous System
Now Past
- ☐ ☐ Headaches or migraines
- ☐ ☐ Tingling or numbness of arms, legs, hands or feet
- ☐ ☐ Pinched nerve or sciatica
- ☐ ☐ Poor balance
- ☐ ☐ Depression or Anxiety
- ☐ ☐ Difficulty dealing with stress
- ☐ ☐ Dizziness or vertigo
- ☐ ☐ Learning disorder or hyperactivity (ADD/ADHD)
- ☐ ☐ Seizures/Epilepsy
- ☐ ☐ Recent progressive muscle weakness or shaking
- ☐ ☐ Numbness of inner thighs/groin

EENT
Now Past
- ☐ ☐ Jaw, TMJ or mouth problem
- ☐ ☐ Visual problems
- ☐ ☐ Ear problems, infections or Ringing
- ☐ ☐ Chronic sinus problems
- ☐ ☐ Face pain

GI/GU/Endocrine
Now Past
- ☐ ☐ Abdominal pain
- ☐ ☐ Constipation/Diarrhea
- ☐ ☐ Heartburn/Acid Reflux/Ulcers
- ☐ ☐ Uncontrolled Bladder or Bowel
- ☐ ☐ Inflammatory bowel disease
- ☐ ☐ Liver or gallbladder problems
- ☐ ☐ Menstrual problems or PMS
- ☐ ☐ Menopause symptoms
- ☐ ☐ Difficulty getting/staying pregnant/other

Cardio-Pulmonary
Now Past
- ☐ ☐ Pacemaker or implanted device
- ☐ ☐ Breathing trouble or Asthma
- ☐ ☐ High blood pressure
- ☐ ☐ History of stroke or aneurysm

Medication-Related Issues
Now Past
- ☐ ☐ Medication dependence
- ☐ ☐ Drug or Vaccination reaction
- ☐ ☐ Current drug side-effects
- ☐ ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ☐ ☐ 3 or more months of steroid medications or intravenous drugs (past or present)

Injuries and General
Now Past
- ☐ ☐ Car crash/whiplash injuries
- ☐ ☐ Work injuries
- ☐ ☐ Ergonomic stress at work
- ☐ ☐ Sports injuries
- ☐ ☐ Smoking habit: How much/day?_____
- ☐ ☐ Drug or alcohol dependence or recovering
- ☐ ☐ Psoriasis or psoriatic arthritis
- ☐ ☐ Unexplained weight loss
- ☐ ☐ Sleeping trouble
- ☐ ☐ Get sick a lot/poor immune function
- ☐ ☐ Fibromyalgia / Chronic fatigue
- ☐ ☐ Tuberculosis, Hepatitis or HIV
- ☐ ☐ Cancer or Tumor
- ☐ ☐ Allergies:_____
- ☐ ☐ Recent fever over 102°F
- ☐ ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ ☐ Constant pain that doesn't improve by changing positions or by lying down
- ☐ ☐ **OTHER HEALTH PROBLEM NOT LISTED**:_____

_____
_____

FAMILY HISTORY:
(circle any that apply)
Back problems - Back/neck surgery - Heart problems – Diabetes - Rheumatoid arthritis - High Blood Pressure - Cancer
Other:_____
_____

LIST ALL SURGERIES AND PROCEDURES YOU HAVE HAD:
_____
_____
_____
_____

LIST ALL MEDICATIONS/VITAMINS/ SUPPLEMENTS/HERBALS:
_____
_____
_____

LIST ANY TRAUMA'S, DATE, AND DESCRIPTION:
_____
_____
_____
_____
_____
_____

Signature:_____
Date:_____

CONSENT TO INITIATE CARE

Welcome to chiropractic care. In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is this office's wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, I ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this practice:

A. **Chiropractic** is a licensed health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.
B. **The Practice of Chiropractic** focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health.
C. **Chiropractic evaluation and examination** is part of the standard chiropractic procedure. It is designed to identify health problems and chiropractic needs. Doctors of Chiropractic focus particular attention on prevention and correction of **Subluxation**.
D. **Subluxation** (particularly of the spine) is a complex of alignment, movement and/or pathological joint abnormalities that chokes off or compromises nerve integrity causing abnormal nervous system and organ system function and ill health.
E. **Chiropractic Adjustment** is a very specific movement of joints, only performed by licensed chiropractors, to eliminate **Subluxation** and allow normal nerve function and health restoration. Chiropractic Adjustments are safe, effective procedures applied over one-million times each day in the United States alone.
F. **Prevention of Subluxation** is accomplished through **maintenance adjustments** and nutritional, mental, and physical wellness habits taught and prescribed by Doctors of Chiropractic.
G. **This office invites you to speak frankly to the doctor or staff** on any matter related to your care at our office. I work to maintain as a supporting, open environment.
H. This office does not seek to replace or compete with medical, dental or other type(s) of health professionals and will provide referral for other evaluation if the doctor feels it is the best interest of his patient. Those providers retain responsibility for the care and management of medical conditions. This office does not offer advice regarding treatment prescribed by other providers.
I. **Your compliance** with Chiropractic Adjustment schedules and instructions is essential to maximum healing and optimal health through Chiropractic. We will work diligently to help you meet your Chiropractic needs.
J. **Cancellation Policy:** Your time is invaluable as is Dr. Hoefen's. Your appointment time is reserved for you and we do our best to give you the care you deserve and need with minimal to no wait. Please give adequate notice for cancelled or rescheduled appointments.

This office is committed to providing the highest quality care possible so that you and your family may enjoy an active, healthy life, with affordable fees. Thank you for taking the first step towards restoring and maintaining your spinal health.

I understand all of the above information and give consent for the chiropractic evaluation and care to be performed by Dr. Heather Hoefen DC.

Patient or Guardian's Signature_____ **Date** _____

Print Name_____

HIPPA Procedures and Authorization

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting my office at (312) 636-0011.

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information given to me and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date:_____