



CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly

Today's Date _____

Whom may we thank for referring You? _____

Have you previously been to a chiropractor? _____ when? _____

Name of previous Chiropractor _____

Personal Information

Name: _____
Last Middle Initial First

Birth Date: ____/____/____ Marital Status: Single Married Divorced
 Widowed Separated

Gender male female

Your Social Security Number _____ - _____ - _____

Address: _____

City: _____ State _____ Zip Code _____

Phone Numbers: Cell _____ Home _____

Email Address _____

Emergency Contact _____ Phone _____

Your Occupation: _____ Employer _____

May we contact you at work? _____ Best number _____

Spouse's Name _____ How many children _____

Insurance Information

Who Carries this policy? Self Spouse Parent _____

Insured's Name _____
(as seen on card) Last Middle First

Insured's Birth Date ____/____/____

Insured's Social Security Number _____ - _____ - _____

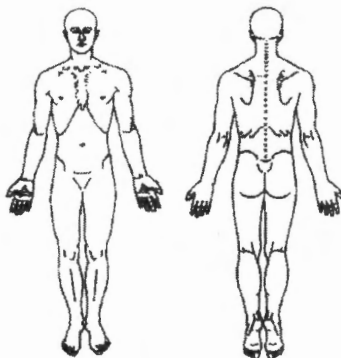
1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other
 A worsening long-term problem
 An interest in: Wellness Other

3. Onset (When did you first notice your current symptoms?)
4. Intensity (How extreme are your current symptoms?)
5. Duration and Timing (When did it start and how often do you feel it?)
0 10
Absent Uncomfortable Agonizing
 Constant Comes and goes. How Often?

6. Quality of symptoms (What does it feel like?)
7. Location (Where does it hurt?)
8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
10. Prior interventions (What have you done to relieve the symptoms?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other



What tends to worsen the problem? _____
What tends to lessen the problem? _____

11. What else should Dr. Hoffman know about your current condition? _____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- Had Have Osteoporosis Arthritis Scoliosis Neck pain Back problems Hip disorders NONE
 Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture Initials _____

b. Neurological

- Had Have Anxiety Depression Headache Dizziness Pins and needles Numbness NONE
Initials _____

c. Cardiovascular

- Had Have High blood pressure Low blood pressure High cholesterol Poor circulation Angina Excessive bruising NONE
Initials _____

d. Respiratory

- Had Have Asthma Apnea Emphysema Hay fever Shortness of breath Pneumonia NONE
Initials _____

e. Digestive

- Had Have Anorexia/bulimia Ulcer Food sensitivities Heartburn Constipation Diarrhea NONE
Initials _____

f. Sensory

- Had Have Blurred vision Ringing in ears Hearing loss Chronic ear infection Loss of smell Loss of taste NONE
Initials _____

g. Skin

- Had Have Skin cancer Psoriasis Eczema Acne Hair loss Rash NONE
Initials _____

Patient name _____

Patient Number
(office use only)

Consultation Notes

Doctor's Initials _____

Precision Wellness & Rehab
Dr. David Hoffman

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name _____

Patient Number
(office use only)

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Consultation Notes

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Doctor's Initials

Precision Wellness & Rehab
Dr. David Hoffman

Signature _____

Date (MM/DD/YYYY) _____