Precision Wellness & Rehab
Dr. David Hoffman
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Ocean Springs, MS 39564
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hoffmanchiropractic@yahoo.com

_____
Patient Number (office use only)

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 seen a chiropractor before? O Yes O No _____ _____
When? If so, whom?

PERSONAL INFORMATION

Name:_____ _____ _____
Last Middle First

_____ _____ _____ _____
Address City State Zip Code

Phone Numbers: _____ _____ _____
Home Cell Email Address

Marital Status: O Single O Married O Divorced O Widowed O Separated

Gender: O Male O Female ____/____/____ _____-_____-_____
Birth Date Social Security Numhnr

_____ _____
Emergency Contact Emergency Contact's Number

_____ _____
Your Occupation Employer

May we contact you at work? O Yes O No Best number to contact you at: _____

_____ How many Children: _____
Spouse's Name

INSURANCE INFORMATION

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

Who carries this policy? O Self O Spouse O Parent ____/____/____ _____-_____-_____
Insured's DOB 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?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10
Absent Uncomfortable Agonizing

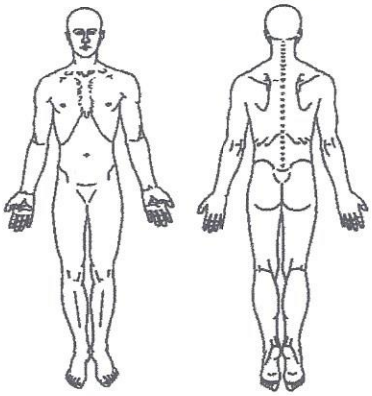
5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

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

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



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.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- ◯ Prescription medication ◯ Surgery ◯ Ice
- ◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
- ◯ Homeopathic remedies ◯ Chiropractic Other _____
- ◯ Physical therapy ◯ Massage _____

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		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

Consultation Notes

Patient name _____

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Doctor's Initials _____

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○ ○ Low energy

Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○ ○ PMS symptoms

Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○ ○ Weakness

Initials ____

Patient name _____

Patient Number (office use only) _____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter): _____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Hoffman about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health Good	Poor	Illnesses	Age at death	Cause of death Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

_____

20. Social History

Tell Dr. Hoffman about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Doctor's Initials _____

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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	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

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? _____

_____

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: _____

_____ _____
Signature Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

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Cancellation/Late Policy

Your appointments and well-being are very important to us. We understand that sometimes unexpected delays can occur causing schedule adjustments. If you need to cancel your appointment, we respectfully request at least a 24hour notice.

Please call if you are not able to arrive on time for your appointment.

Please rebook for a later date if you are coughing, running any fever or contagious.

No massages will be given to those on pain medication, drugs or alcohol.

Confirmation calls may be made from this office approximately 24 hours prior to all appointments to confirm time.

Cancellations must be made no later than the close of business 1 day prior to appointments.

Arrival late to an appointment will result in reduced time or cancellation of that appointment.

For massage appointments: arriving 10min late for a 30 min massage or 20 min late for a1 hour massage will result in cancellation and a charge of $50. These fees will be added to the patients account and must be paid prior to rebooking.

No call/no show will be charged $50 for a missed chiropractic appointment to be paid prior to rebooking.

Fees will be accessed on an individual basis. Elements beyond individual control are understood such as death, illness, or acts of nature.

After 3 no call/no shows we reserve the right to refuse rebooking in the future.

I understand and agree to the policy set forth

_____

Print Name Date

_____

Patient/Guardian Signature