Hennicken Family Chiropractic

Member ID # _____ *for office use only)* Date: ____/____/____

Your Information:

Name (Mr., Mrs., Ms., Dr.) _____ H. Phone _____

Home Address: _____ C. Phone _____

City: _____ State: _____ Zip Code _____

SS#: _____ Email: _____

Age: _____ Date of Birth: ____/____/____ Single / Married / Widowed / Divorced / Other: _____

Occupation: _____ Employer: _____

Address, City, State: _____ W. Phone _____

Your Family:

Spouse's Name _____ SS#: _____ # of Children: _____ Age's: _____

Spouse's Employer: _____ Spouse's Date of Birth: ____/____/____

Health Care Information:

Previous Chiropractic Care: YES NO Doctor: _____ Last Visit: ____/____/____

Current Medical Doctor: _____ Last Visit: ____/____/____

Health Insurance:

Insured on Policy: _____

Name of Health Ins Company: _____

(We will need to make copies of your Insurance Card(s) and Driver's License)

Reason for seeking care:

_____ ____/____/____

Major Complaint or Concern — Onset of condition

_____ _____ _____

In case of emergency contact — Relationship — Phone Number

How did you hear about us? ↓ Or did someone refer you here Their name _____

Live Nearby / Activator.com / Yellow Book / Talking Phone Book / Yellow Pages / Website / Online Phone Book / Health Fair

It is usual and customary to pay for services as rendered unless otherwise arranged

I do hereby authorize Dr. Paul J. Hennicken to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis and etc. of myself in regards to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him or her for chiropractic service rendered to me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him or her for service rendered to me. This agreement is made solely for the said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he or she will not await payment but may declare the entire balance due and payable/these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient Signature: _____ Date: ____/____/____

Over Please ➡

CASE HISTORY

Thank you for completing this detailed health history. Please circle each individual answer and provide additional information when indicated. Include both ***past*** and ***present*** conditions. If you are not sure what a question means, leave it blank and your doctor will review it with you later.

Family History			
001	Y	N	Diabetes
002	Y	N	Thyroid disease-
003	Y	N	Kidney disease-
004	Y	N	High blood pressure
005	Y	N	Heart disease-
006	Y	N	Musculoskeletal disease
007	Y	N	Cancer-
008	Y	N	Stroke
009	Y	N	Other family history
Patient's Current General History			
010	Y	N	Recent weight change, ↑ ↓
011	Y	N	Periodic unexplained sweats
012	Y	N	Reoccurring Allergies
013	Y	N	Anemia
014	Y	N	Malaise / fatigue / weakness
015	Y	N	HIV positive
016	Y	N	Cancer-
017	Y	N	Thyroid conditions:
018	Y	N	Diabetes
019	Y	N	Neck surgery / irradiation
020	Y	N	Other:
Reproductive System			
021	Y	N	Genital lesions
022	Y	N	Genital mass / growths / pain
023	Y	N	Other:
Neurological System			
024	Y	N	Headaches,How often? _____
025	Y	N	Seizures / Epilepsy
026	Y	N	Tics / twitches / spasms
027	Y	N	Dizziness
028	Y	N	Numbness or tingling
029	Y	N	Unusual weakness
030	Y	N	Head Trauma
031	Y	N	Stroke
032	Y	N	Disk herniation
033	Y	N	Other-
Cardiovascular System			
034	Y	N	Shortness of breath From exercise? Y N
035	Y	N	Chest discomfort / pain
036	Y	N	Palpitations
037	Y	N	Edema
038	Y	N	Fainting
039	Y	N	Sudden calf pain while walking
040	Y	N	High BP – Medication Y N
041	Y	N	Past heart disease
042	Y	N	Rheumatic fever
Hospitalizations / Medications			
043	Y	N	Have you ever been hospitalized or had surgery?
044	Y	N	Current medications or drugs Medication

Eye / Ear / Nose / Throat			
045	Y	N	Corrective Lenses
046	Y	N	Eye Pain
047	Y	N	Other Visual Conditions:
048	Y	N	Glaucoma
049	Y	N	Difficulty hearing / deafness
050	Y	N	Ringing in ears / dizziness
051	Y	N	Ear pain
052	Y	N	Change in ability to smell
053	Y	N	Sinus pain or congestion
054	Y	N	Hoarseness
055	Y	N	Change in voice
056	Y	N	Difficulty chewing / swallowing
057	Y	N	Enlarged / painful glands
058	Y	N	Other:
Breasts (Male and Female)			
059	Y	N	Breast lumps / mass / growths / pain / tenderness
060	Y	N	Dimples in breast
061	Y	N	Change in color / size / shape
062	Y	N	Nipple discharge / bleeding
063	Y	N	Other:
Pulmonary System			
064	Y	N	Difficulty breathing
065	Y	N	Cough
066	Y	N	TB exposure / test / X-Ray
067	Y	N	Cigarettes: past / present
068	Y	N	Other tobacco: past /present
069	Y	N	Other:
Skin / Hair / Nails			
070	Y	N	Change in skin texture
071	Y	N	Change in skin temperature
072	Y	N	Skin dryness or perspiration
073	Y	N	Unusual skin coloration
074	Y	N	Rashes / itching / lesions
075	Y	N	Skin growths
076	Y	N	Mole changes
077	Y	N	Skin Cancer-
078	Y	N	Skin Pain-
079	Y	N	Other:
Psychological History			
080	Y	N	Anxiety
081	Y	N	Depression
082	Y	N	Hospitalization for psychological care
083	Y	N	ADHD or Bipolar
084	Y	N	Other:
Implants / Orthopedic Supports			
085	Y	N	Breast implants
086	Y	N	Cardiac (pacemaker, etc.)
087	Y	N	Joint Implants-
088	Y	N	Other Implants / Supports (including heel or sole lifts) Type?
089	Y	N	Pins / Plates / Staples?

Gastrointestinal System			
090	Y	N	Change in appetite
091	Y	N	Food intolerance
092	Y	N	Nausea / vomiting
093	Y	N	Vomiting of blood
094	Y	N	Peptic ulcer
095	Y	N	Indigestion / Heartburn
096	Y	N	Abdominal pain (stomach)
097	Y	N	Abdominal swelling
098	Y	N	Abnormal flatulence (gas)
099	Y	N	Change in bowel habits or stool (color, consistency etc.)
100	Y	N	Diarrhea / Constipation
101	Y	N	Gallbladder disease
102	Y	N	Liver disease
103	Y	N	Pancreas disorder
104	Y	N	Alcohol intake
105	Y	N	Other:
Urinary System			
106	Y	N	Frequent urination
107	Y	N	Increased thirst?
108	Y	N	Change in urine
109	Y	N	Hesitancy
110	Y	N	Urethral discharge
111	Y	N	Urinary tract infections
112	Y	N	Kidney disease / Stones
113	Y	N	Mid back/flank (side) pain
Musculoskeletal System			
114	Y	N	Joint stiffness/change in motion
115	Y	N	Joint pain
116	Y	N	Joint swelling
117	Y	N	Muscle cramps
118	Y	N	Muscle weakness
119	Y	N	Muscle wasting
120	Y	N	Neck pain
121	Y	N	Upper / mid back pain
122	Y	N	Low back pain
123	Y	N	Buttock pain
124	Y	N	Shoulder / arm / hand condition: Left Right
125	Y	N	Leg / knee / ankle / foot condition : Left Right
126	Y	N	Fractures / dislocation / sprains: Location:
127	Y	N	Other injuries – include auto accidents
128	Y	N	Other:
Other			
129	Is there anything else we need to know about you? _____ _____ _____ _____		

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ Patient Intials

_____ Date