



Hartwell Chiropractic & Wellness Center

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170 NW 2nd Avenue, Canby, OR 97013

Confidential Patient Information (please print clearly)

Date: _____

Cell/ Home Phone: _____

Referred By: _____

Work Phone: _____

Appt. Reminder Call? Yes, No

E-mail Address: _____

Name: _____

Last First Middle

Home Address: _____

Street Address Apt./Condo

Number

City State Zip Code

Driver's License # _____ State _____ SSN# _____

Age _____ Birthdate ____/____/____ Weight _____lb. Height: _____' _____"

Employer's Name: _____ Occupation: _____

Address: _____

Nearest Relative Not At your Residence _____ Phone #: _____

Spouse / Parent Information

Their name: _____

Last First Middle

Employer: _____ Address: _____

Work Phone # _____

Number of Children _____ Their names: _____

Patient Agreement/Release of Records/Consent

Our office policy requires payment at the time of treatment for all cash paying, Medicare, and personal insurance patients with unmet deductibles, unless other arrangements have been made with the office manager. Although we are billing insurance companies if applicable, we hold you responsible for your account.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE AND AGREE TO PAY SUCH CHARGES FOR SERVICES RENDERED. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION TO SECURE PAYMENT OF BENEFITS.

Chiropractic examination and therapy procedures (including spinal manipulation, ultrasound, electrotherapy, heat and ice application, and manual muscle therapy) are considered very safe and effective methods of care. Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to soreness, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding payment policy, and possible treatment side-effects. I also understand that there is no guarantee for specific cure or result.

Signature of Patient

Date

Personal Health History

All information will be kept strictly confidential. Your response will help determine if chiropractic treatment will benefit you. If we do not believe your condition will respond satisfactorily, we will refer you to the appropriate physician.

Reason for visit and/or Present Complaints: (Describe): _____

Please check the activity (s) that increase or bring about your pain:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bending
<input type="checkbox"/> Lifting
<input type="checkbox"/> Twisting
<input type="checkbox"/> Stooping | <input type="checkbox"/> Sitting
<input type="checkbox"/> Standing
<input type="checkbox"/> Walking
<input type="checkbox"/> Running | <input type="checkbox"/> Pushing
<input type="checkbox"/> Pulling
<input type="checkbox"/> Carrying
<input type="checkbox"/> Weather Changes | <input type="checkbox"/> Sleeping
<input type="checkbox"/> Jumping
<input type="checkbox"/> Driving
<input type="checkbox"/> Throwing |
|--|---|---|--|

Have you seen a chiropractor? Yes, No, If yes where and when? _____

C = Current, P = Past, Please place a "C" or "P" in front of the following conditions you have or have had. We need your complete health report before we can be responsible for your case.

Muscle/ Joint

- __ Arthritis
- __ Bursitis
- __ Hernia
- __ Low Back Pain
- __ Neck Pain
- __ Stiff Neck
- __ Pain Between Shoulders
- __ Swollen Joints

Pain / Numbness

- __ Shoulders
- __ Arms
- __ Elbows
- __ Hands
- __ Hips
- __ Legs
- __ Knees
- __ Feet

Cardiovascular

- __ Arteriosclerosis
- __ Hardening of arteries
- __ High blood pressure
- __ Heart Disease
- __ Low blood pressure
- __ Pain over heart
- __ Poor circulation
- __ Pacemaker
- __ Rapid / Slow heartbeat
- __ Stroke

General

- __ Allergy: (food)
- __ Allergy: (environmental)
- __ Anxiety
- __ Convulsions
- __ Cancer (Where? _____)
- __ Dizziness
- __ Epilepsy
- __ Fainting
- __ Fatigue
- __ Headache
- __ Nervousness
- __ Loss of sleep
- __ Poor posture
- __ Sciatica
- __ Low Energy
- __ Spinal Curvature
- __ Swelling of ankles
- __ Weight Loss (abnormal)
- __ Weight Gain (abnormal)

Skin

- __ Acne
- __ Bruise easily
- __ Eczema
- __ Hives
- __ Itching
- __ Varicose veins

Head

- __ Colds
- __ Deafness
- __ Dental decay
- __ Ear ache
- __ Ear ringing
- __ Enlarged glands
- __ Eye pain
- __ Failing vision
- __ Gum trouble
- __ Hay fever
- __ Hoarseness
- __ Nose Bleeds
- __ Sinus infection
- __ Sore throat

Respiratory

- __ Asthma
- __ Chronic cough
- __ Difficulty breathing
- __ Wheezing
- __ Bronchitis
- __ Emphysema
- __ Smoker (How long? _____)

Genitourinary

- __ Bed-wetting
- __ Bladder infection
- __ Blood in urine
- __ Frequent urination
- __ Kidney infection
- __ Painful urination
- __ Prostate trouble

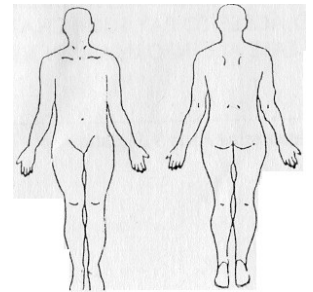
Gastrointestinal

- __ Appendicitis
- __ Belching or gas
- __ Bloating abdomen
- __ Colitis
- __ Colon trouble
- __ Constipation
- __ Diarrhea
- __ Difficult Digestion
- __ Excessive hunger
- __ Gallbladder trouble
- __ Hemorrhoids
- __ Intestinal worms
- __ Liver trouble
- __ Nausea
- __ Pain over stomach
- __ Poor appetite
- __ Ulcers
- __ Vomiting
- __ Vomiting of blood

Misc. Conditions:

- __ Alcoholism
- __ Anemia
- __ Cold Sores
- __ Diabetes – I or II?
- __ Edema
- __ Fever blisters
- __ Goiter
- __ Gout
- __ Herpes
- __ Multiple Sclerosis
- __ Polio
- __ Rheumatic fever
- __ Scarlet fever
- __ Tuberculosis

Please mark your areas of pain on the diagram below



Women Only

- __ Cramps
- __ Fibrocystic breasts
- __ Excess menstrual flow
- __ Hot flashes
- __ Irregular cycle
- __ Lumps in breasts
- __ Menopause
- __ Miscarriage
- __ Painful menstruation
- __ Vaginal discharge

Are you pregnant?

Yes No

If yes, how long?

__ months

Number of prior pregnancies __?