Hartwell Chiropractic & Wellness Center, P.C.

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Confidential Patient Information (please print clearly)

Date: _____ **Home Phone:** _____

Referred By: _____ **Work Phone:** _____

Appt. Reminder Call? ☐ **Yes,** ☐ **No** **Cell Phone:** _____

For Reminders please call: Home/Cell/Work **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 Information (Parent Information if patient is a minor)

Their name: _____
Last First Middle

Employer: _____ **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.

I have read and understand the above statements regarding payment policy. I also understand that there is no guarantee for specific cure or result.

_____ _____
Signature of Patient Date

For office use only:

_____ **(**Reviewed previous health complaints with patient)

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:

☐ Bending	☐ Sitting	☐ Pushing	☐ Sleeping
☐ Lifting	☐ Standing	☐ Pulling	☐ Jumping
☐ Twisting	☐ Walking	☐ Carrying	☐ Driving
☐ Stooping	☐ Running	☐ Weather Changes	☐ Throwing

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

Have you had any surgeries in the past ☐ Yes, ☐ No, If yes where and when _____
Do you have any allergies: Food_____ Environmental _____ Medication_____

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
__ 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)
__ Osteoporosis

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
__ TMJ

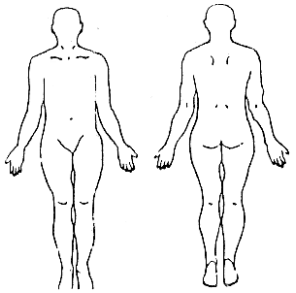
Respiratory
__ Asthma
__ Chronic cough
__ Difficulty breathing
__ Wheezing
__ Bronchitis
__ Emphysema
__ Smoker (How long? _____)

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

Gastrointestinal
__ Acid Reflux
__ Appendicitis
__ Belching or gas
__ Bloated abdomen
__ Colitis
__ Colon trouble
__ Constipation
__ Diarrhea
__ Difficult Digestion
__ Excessive hunger
__ Gallbladder trouble
__ Hemorrhoids
__ IBS
__ 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
__ Thyroid
__ Tuberculosis

Please mark your areas of pain on the diagram below



Women Only
__ Cramps
__ Fibrocystic breasts
__ Breast Augmentation
__ Excess menstrual flow
__ Hot flashes
__ Irregular cycle
__ Lumps in breasts
__ Menopause
__ Miscarriage
__ Painful menstruation
__ Vaginal discharge
____ If yes, when?

Are you pregnant?
☐ Yes ☐ No
If yes, how long?
___ months
# of prior pregnancies
___?