Welcome to our office.

Date:___/___/____ Whom can we thank for referring you: ______________________

Patient Information

_____________________________ ______-_____-________ ________ ____/_____/________
First, Middle, Last Name Social Security # Age Date of Birth

Address City State Zip Code

Home Phone # Work Phone # Mobile Phone # E-Mail

Sex: ☐Male ☐ Female

Nicknames Prior Name

Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed # of Children______ Spouse's name________________

_____________________________ M.D. _______-______- _________
Medical doctor Phone#

Employment Information

Employment Status: ☐Full Time ☐Part Time ☐ Student ☐ Retired or Disabled ☐ Unemployed

Occupation Employer/ Company Name Employers Phone #

Address City State Zip Code

Relative to Contact in Case of Emergency (Not living in Home of Patient)

Name Phone # Relationship to Patient

Address City State Zip Code

*** If insurance card is not in your name fill out section below:**

Primary Insurance Card Holder: ☐Spouse ☐ Parent ☐ Other ______________

_____________________________ ______ -______- ________ ___/____/_____
First, Middle, Last Name Social Security # Date of birth

Address City State Zip Code

Home Phone # Work Phone # Mobile Phone # E-Mail

*Employer Employers Address City State Zip Code

Secondary Insurance Cardholder: Relationship to you______________________

_____________________________ _____-______-__________ ____/____/______ ________________
First, Middle, Last Social Security # Date of birth

Address City State Zip Code

Home phone # Work phone # Mobile phone # E-mail address

Employer Employer's address City State Zip code

Name________________________________ Date____/____/______

Assignment and Release of Primary Insurance Benefits

If you want benefits to be sent to Hanley Chiropractic HealthCare directly please read and then sign the following.

I, the undersigned certify that I (or my dependent) have insurance coverage with___________________________________ and assign directly to Hanley Chiropractic HealthCare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that all charges that are denied which may include any insurance, workers compensation and personal injury claims are my responsibility and are to be paid in full. I hereby authorized Hanley Chiropractic HealthCare to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

____ _________________ ____

Responsible Party Signature Date Relationship

Consent to Treat and Financial Responsibility (initial each section)

_________ I voluntarily consent to receive Chiropractic healthcare services from Dr. Stuart D. Hanley D.C. or whomever he may designate as his assistants and/or associates to administer treatment, examinations as well as diagnostic and chiropractic procedures for spinal and/or extremity subluxation only.

_________ I fully understand and agree that all services rendered to me are directly my responsibility and that I am personally responsible for all charges due to Hanley Chiropractic HealthCare. I also understand that should my account fall delinquent that my account may be turned over for legal collection and reported to the credit bureau. In the event that my account is turned over for collection I agree to pay the cost of collection, including reasonable attorneys fees.

____ ___________________

Patient's Signature Date

To facilitate ease of payment after insurance is processed and/or in the event of nonpayment as agreed above.

❑ I authorize this office to charge my credit card indicated below for the total amount due on my account.

❑Visa ❑ MasterCard ❑Discover ________ - ________ - ________ - ________ _____/__________ __________

Credit Card # Expiration Sec Code

____ ____

Cardholders Name Cardholders Signature

If patient is under 18, parent or guardian must complete this portion.

Consent to Treat a Minor (if patient is under 18)

I (we) being the parent, guardian or custodian of the minor being____, age _________, do hereby authorize, request and direct Dr. Stuart D. Hanley D.C. and whomever he designates as his assistants and/or associates to perform examinations, diagnostic procedures including x-rays, laboratory tests and any treatment that in their judgment is deemed advisable or required. It is the understanding of the undersigned that the doctor and their staff will have full authority from me as legal parent/guardian to continue with examinations diagnostic procedures and tests and treatments as will be needed while said minor showed above is under care in this office until legal age is obtained.

As legal parent/guardian I realize full responsibility for all charges and payments due.

____ ____________________ _________________________________

Parent, Guardian or Custodian Signature Date Witness

Hanley Chiropractic HealthCare 955 Factory Road, Beavercreek, OH 45434 P# 937-426-4545 F# 937-426-4548

114 West Washington Street, Jamestown, Ohio 45335 P# 937-675-6767 F# 937-675-2794

Name__________________________________ Date____/_____/______

Name of Attorney, if auto accident or work-related: ____

ATTENTION: If question does not apply put N/A in the space.

Is your condition related to: ☐ work injury ☐ auto accident or personal injury

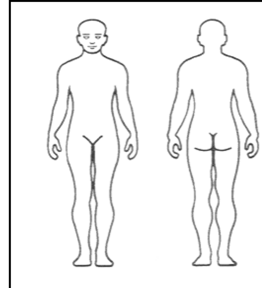
Complaints: Mark area of complaints on the figure to the right with an X also if pain radiates please mark where it radiates with arrow.

#1 problem ____

#2 problem ____

#3 problem ____

#4 problem ____



PAIN SCALE
Circle a # (1 Least-10 Most)

Neck _______________ 1 2 3 4 5 6 7 8 9 10

Mid Back_______________ 1 2 3 4 5 6 7 8 9 10

Low Back_______________ 1 2 3 4 5 6 7 8 9 10

Arms _______________ 1 2 3 4 5 6 7 8 9 10

Legs _______________ 1 2 3 4 5 6 7 8 9 10

When did it start? (Approx. time or Date) _______/________/___________

How and Where did the condition start (fall, strain, no apparent reason, etc.)____

Condition is: ☐ improving ☐ getting worse ☐ no change ☐ worse with movement

It feels: ☐ achy ☐ burning ☐dull ☐ sharp ☐ throbbing ☐ shooting ☐ cramping ☐ stabbing

Is it: ☐ mild ☐ moderate ☐ severe ☐ agonizing

Pain/condition is: ☐ constant ☐ frequent ☐ intermittent ☐ occasional

Does pain radiate or refer into another area? ☐ no ☐ yes, into my ____

Also have: ☐ decreased range of motion or movement ☐ numbness ☐ tingling ☐ spasms ☐ weakness ☐ swelling/inflammation

What makes condition worse: ☐ nothing ☐ driving ☐ lifting ☐ movement ☐ resting ☐ sleeping ☐ sitting
☐ standing ☐ walking ☐ working ☐ bending ☐ breathing

What makes condition better: ☐ nothing ☐ cold ☐ chiropractic care ☐ massage ☐ medication ☐ movement
☐ restin ☐ sleeping ☐ walking ☐ warmth

Headache is: ☐ none ☐ front of head ☐ side of head ☐ back of head
☐ morning ☐ as day progresses ☐ afternoon ☐ during the day ☐ evening ☐ upon awakening ☐ constant

Habits: **tobacco:** ________ x/day **tobacco** used in the past, but none now never used tobacco
alcohol: ______ drinks/wk **Caffeinated coffee/tea /soda** _________ servings/day **artificial sweetener**

Please list all current drugs (prescription and OTC): ____
____

Surgeries/hospitalizations for : ❑spinal/joint __________________________________ ❑ cancer _______________________
❑ other ____

Past or present major illnesses ❑ none ❑pacemaker/heart ❑ diabetes ❑ stroke ❑ cancer (type) __________________________
❑radiation ❑ chemotherapy ________ yrs/months ago ❑ treatment is ongoing ❑ spinal condition (scoliosis, congenital defect, etc.)

Recent tests (within 2 yrs. Body part and mo/yr): ☐ MRI ______________ ☐ C-T _______________☐ x-rays _____________________

Name________________________________ Date_____/______/_______

History: Check if YOU have now or have had any of the following:

___Fractured bones	___Loss of Memory	___Chest pain
___Auto accidents ____0-1 yrs ago	___Learning Disability	___Asthma
____1-5 yrs ago	___Mistake sidedness (R from L)	___Lung problems
____ more than 5 years ago	___Stutter	___Difficulty breathing
	___Dyslexia	___Wheezing
___Other accidents/falls	___Mood changes	___Heart problems
___Knocked unconscious	___Lose temper easily	___Stroke
___Back curvature	___Headache	___High or low blood pressure
___Mental or emotional disorders	___Neck pain or stiff R or L	___Varicose veins
___Arthritis	___Numbness, tingling, or pain in arms, hands, fingers R or L	___Liver trouble
___Diabetes		___Gallbladder trouble
___Swollen or Painful joints	___Jaw pain or click/TMJ R or L	___Digestive problems
___Convulsions/Epilepsy	___Head seems too heavy	___Excess gas
___Skin problems	___Head and shoulders feel tired	___Belching/bloating after meals
___Itching	___Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties)	___Heartburn
___Bruising		___Ulcers
___Cancer		___Diarrhea/constipation
___Frequent Colds/Flu	___Shoulder pain R or L	___Colon trouble
___Nervous	___Dizziness	___Hemorrhoids
___Tension	___Ringing in ears R or L	___Prostate problems
___Depressed	___Hearing loss R or L	___Impotence
___Irritable	___Fainting	___Kidney problems
___Anemia	___Loss of balance	___Kidney stones
___Excessive Sweating	___Blurred or double vision R or L	___Frequent urination
___Tremors	___Upper back pain or stiffness R or L	___Discharge
___Light bothers eyes	___Midback pain or stiffness R or L	___Menstrual problems/PMS
___Allergy	___Lower back pain or stiffness R or L	___Menopause problems
___Sinus Problems	___Numbness, tingling or pain in the buttocks, thighs, legs, feet, toes R or L	___Breast lumps, soreness, discharge
___Lightheaded upon rising		___Pregnant (now)
___Under stress	___Pain with cough, sneeze or strain at the stool	___Bedwetting
___Crave Sweets or Salts		___Ear infections
___Eating disorders	___Hip pain R or L	___Hepatitis
___Trouble Sleeping	___Foot trouble R or L	___Venereal disease
___Trouble Concentrating		___AIDS/HIV

Family History: F (father) M (mother) S (sibling) C (child) *Circle all that apply.*

☐ cancer : F M S C (name types) ____

☐ stroke F M S C ☐ heart attack F M S C ☐ diabetes F M S C ☐ depression F M S C

Most recent Chiropractic care(approx. date - mm/yy) **:** ______/_____ Dr. ________________________________ D.C.

Approximately how many Chiropractic visits have you had in your life: ____________

Work activities physical(factory,trade, lifting,etc.) sedentary(desk,computer,office,etc.) combination (some paperwork, some heavy lifting, etc.)

Current work status due to condition: ☐ none missed ☐ light-duty ☐occasionally missed ☐ working part-time ☐ have not returned to work ☐ returned to work but unable to continue ☐ off work then returned on_____/_____/_____ ☐ retired ☐ unemployed

Exercise (not work-related) none daily ______ x/wk never

Type cardio resistance/weights ______ yoga/pilates

Past treatment for <u>this</u> condition: ☐ none ☐ Chiropractic care ☐ over-the-counter medications ☐ physical therapy ☐ prescription medications ☐ cortisone injections ☐ surgery to area of concern ☐ massage

How long ago? ____ **Did it help?** ☐ yes ☐ no