Hanley Chiropractic HealthCare
"Committed to Your Health"

Welcome to our office.

Date:_____,20___ Whom can we thank for referring you: _____

Patient Information

_____ _____ _____ _____ _____ _____ **Sex**:❑ Male ❑ Female
First, Middle, Last Name | Social Security # | Age | Date of Birth

_____ _____ _____ _____
Address | City | State | Zip Code

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

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

Primary Insurance Card Holder: ❑Spouse ❑ Parent

_____ _____-_____-_____ ___/___/_____ _____
First, Middle, Last Name | Social Security # | Date of birth | Relationship to Patient

_____ _____ _____ _____
Address | City | State | Zip Code

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

_____ _____ _____ _____ _____
Employer | Employers Address | City | State | Zip Code

Secondary Insurance Cardholder (if applicable):

_____ ____-_____-_____ ____/____/_____ _____
First, Middle, Last | Social Security # | Date of birth | Relationship to patient

_____ _____ _____ _____
Address | City | State | Zip Code

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

_____ _____ _____ _____ _____
Employer | Employer's address | City | State | Zip code

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

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 and diagnostic 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

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 _____-_____-_____-_____ _____

Credit Card # Expiration

_____ _____

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

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

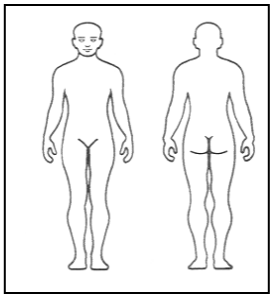
Complaints: Mark area of complaints on the figure to the right with an X also if pain radiates please mark where it radiates with arrow.

#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.)_____

Is the condition: ❑ improving ❑ getting worse ❑ no change ❑ worse with movement

Is it: ❑ achy ❑ burning ❑ dull ❑ sharp ❑ throbbing ❑ shooting ❑ cramping ❑ stabbing

Have you noticed: ❑ decreased range of motion or movement ❑ numbness ❑ tingling ❑ spasms ❑ weakness ❑ swelling/inflammation

Is it: ❑ mild ❑ moderate ❑ severe ❑ agonizing

Is the pain/condition: ❑ constant ❑ frequent ❑ intermittent ❑ occasional

Does pain radiate or refer into another area? ❑ no ❑ yes, into my _____

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 ❑ resting ❑ sleeping ❑ walking ❑ warmth

Headache is where: ❑ none ❑ front of head ❑ side of head ❑ back of head

When is the headache: ❑ morning ❑ as day progresses ❑ afternoon ❑ during the day ❑ evening ❑ sleep ❑ constant

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 _____

Family History: F (father) M (mother) S (sibling) C (child)

❑ cancer (name type)**:** _____

❑ stroke _____ ❑ heart attack _____ ❑ diabetes _____ ❑ depression _____

Habits: ❑ tobacco x/day_____ ❑ tobacco used in the past, but none now ❑ never used tobacco

❑ alcohol - drinks/wk_____ ❑ Caffeinated coffee/tea /soda servings/day _____

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

Exercise (not work-related) ❑ none ❑ daily ❑ _____ x/wk ❑ never **Type** ❑ cardio ❑ resistance/weights ❑ _____ yoga/pilates

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Name_____ Date_____

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

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

When did you first see a Chiropractor: ❑infant ❑ child ❑ teen ❑ adult Approx date of first visit: (mm/yy) _____/_____

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

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

Mark on the health scale below where you think your health and energy level is **presently** based on how you move, eat, and your emotions

0_____**10**

Dead Functioning at peak level

What important/fun activities can you no longer do?_____

Does condition interfere with: ❑ activities of daily living (bathing, cooking etc.) ❑ normal lifestyle ❑ sleep ❑ recreation ❑ work

What activities are you looking forward to doing after your condition has improved? _____

Current work status due to condition: ❑ none missed ❑ light-duty ❑occasionally missed ❑ working part-time ❑ have not returned to work ❑ return to work but unable to continue ❑ was off work then returned on_____ ❑ retired ❑ presently not employed

Present or past treatment for this condition: ❑ none ❑ Chiropractic care ❑ over-the-counter medications ❑ physical therapy ❑ prescription medications ❑ cortisone injections ❑ surgery to area of concern ❑ massage **Did it help?** ❑ yes ❑ no

How long ago did you receive this treatment: _____

In order to serve you needs better do you want care based on :

- ❑ pain and symptom relief only
- ❑ pain and symptom relief along with getting as much joint movement and function as possible

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

Name_____ Date_____

Automobile Accident Details

Date of accident: _____,20___
Time of accident: _____ AM or PM ❑ Dawn ❑ Daylight ❑ Dusk ❑ Night

Location(nearest intersection with the road/street and direction)**:**
_____
_____
_____

Accident description:
_____
_____
_____
_____

Did the car go off the road? ❑ yes ❑ no **Length of time you were in the car before accident:** _____min/hrs

Body parts that were struck during the collision: _____
_____

Your position in the car: ❑ driver ❑ passenger (which seat)
_____
Your status before the accident (may answer more than one)**:** ❑ tired ❑ asleep ❑ awake ❑ reclined in the seat
❑ rotated in the seat ❑ seat belt on ❑ seat belt off ❑ shoulder harness on ❑ shoulder harness off
What was the posted speed limit: _____mph **How fast were you traveling before impact:** _____mph

Were citations given: ❑ yes ❑ no **Reason citation was given:** _____
Was an accident/injury report filed: ❑ yes ❑ no
Accident was reportedto:_____
Any witnesses?: ❑yes ❑no

Traffic conditions: ❑ normal ❑ good ❑ heavy ❑ congested ❑ rush-hour
Where was your vehicle impacted: ❑ front ❑ rear ❑ left side ❑ right side

Make model and year of your vehicle:_____
Make model and year of the other vehicle: _____

Weather conditions: ❑ normal ❑ foggy ❑ icy ❑ poor visibility ❑ raining ❑ snowing ❑ windy ❑ other:
_____

Location you were taken after the accident: ❑ home ❑ hospital ❑ emergency room ❑ minor emergency center ❑ other _____
Were you hospitalized(admitted overnight or longer)**:** ❑ yes ❑ no
What tests (ie. X-rays MRI etc.) **and treatment** (ie. drug surgery etc)**did you receive:**
_____
_____

<u>Functional Assessment</u>
Have you notice limitations using your: ❑ neck ❑ shoulders ❑ arms ❑ hands ❑ back ❑ legs ❑ feet ❑ bowel/bladder ❑ other_____
Do you have pain when: ❑ lifting over _____lbs. ❑ sitting over ____min/ hrs. ❑ bending ❑ standing ❑ walking ❑ climbing ❑ reaching ❑ squatting ❑twisting ❑ crawling