Hofman Chiropractic & Wellness

Patient Name: _____ Birthdate: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____ Driver Lic. #: _____

Occupation: _____ Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

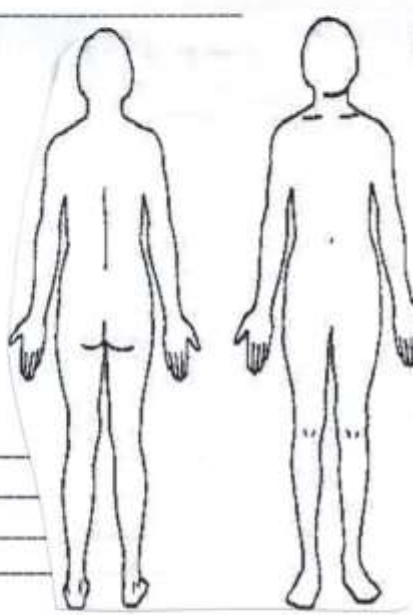
Subscriber Name: _____ Health Plan: _____

Subscriber ID: _____ Group #: _____ Spouse Name: _____

Spouse Employer: _____ City: _____ State: _____ Zip: _____

Primary Care Physician Name; _____ PCP Phone: _____

MARK "x" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Headache Neck Pain Mid-back Pain Low Back Pain

Other _____

Is this? Work Related Auto Related N/A

Date Problem Began: _____

How Problem Began: _____

Current Complaint (how you feel today): 0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? O-25% 26- 50% 51-75% 76-100%

Can you perform your daily activities? Yes No Describe Current activity limitations: _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes Date(s) taken:_____

WHAT AREAS WERE TAKEN? _____

Please check the following that apply to you: None Apply

No	Yes	Condition	No	Yes	Condition	No	Yes	Condition
__	__	History of Recent Infection	__	__	Prostate Problems	__	__	Urinary Retention
__	__	Recent Fever	__	__	Frequent Urination	__	__	Aortic Aneurysm
__	__	HIV/AIDS	__	__	Pregnancy, # of births _____	__	__	Cancer/Tumor
__	__	Diabetes	__	__	Abnormal Wt. __ Gain __ Loss	__	__	Osteoporosis
__	__	Corticosteroid Use	__	__	Epilepsy/Seizures	__	__	Recent Trauma
__	__	Birth Control Pills	__	__	Visual Disturbances	__	__	Numbness inGroin/Buttocks
__	__	High Blood Pressure	__	__	History of Low/Mid Back Pain	__	__	History of Alcohol Use
__	__	Stroke (date) _____	__	__	History of Neck Pain	__	__	History of Tobacco Use
__	__	Dizziness/Fainting	__	__	Arthritis			

Surgeries/Medications:_____

_____

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Family History: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Cardiovascular Problems/Stroke

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contract my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary. Certain insurances do not cover the following therapies: Electro-Acuscope Therapy, Electrical Stimulation, Manual Therapies; therefore I acknowledge that I will be financially responsible for payment if these therapies are included in my treatment.

Patient Signature _____ **Date**_____