Patient Information

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Last Name ______________________ **First Name** ________________________ **Middle Initial** ________

Name you prefer to go by: ____________________ **Date of Birth** ________ / ________ / ________

SS# ___________________________

Gender: ❒ M ❒ F **Marital Status:** ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Partnered

Home Address ____ **Apt #** __________

City ______________________________ **State** ______________ **Zip** ________________

Home Phone # ________________ **Cell Phone #** ________________ **Work Phone #** ________________

Primary Number: ❒ Home ❒ Work ❒ Cell **Secondary Number:** ❒ Home ❒ Work ❒ Cell

Please note: text and email reminders are sent with minimal personal information. These messages are sent securely with our software, but once it reaches your phone/computer it is only as safe as you and your phone/email company's security.

☐ **Text appointment reminders**

☐ **Email appointment reminders** **email address:** ______________________________

Your Employer ______________________________ **Occupation** ______________________________

Emergency Contact ______________________ **Phone Number** ________________ **Relation** ____________

Whom may we thank for your referral? ____

CONDITION **Workers Compensation Related?** ❒ Yes ❒ No **Auto Accident Related?** ❒ Yes ❒ No

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury.

The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Fort Wayne Chiropractic I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon request.

***Signature** ______________________________________ **Date** ________________

My Privacy

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Fort Wayne Chiropractic to ensure the privacy of my personal health information.

***Signature** ______________________________________ **Date** ________________

Fort Wayne Chiropractic

Dr. Gregory J. Hough, D.C.

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name (print): ___________________________________ **Date of Birth:** ___________________

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Date of permission	**Name** of individual & **Relationship** with patient (parents for minors and spouses must be added if they are to have any access)	**Specify Information Allowed** (i.e. may call about appointment, may check balance, full access, etc.)
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________

DR. HOUGH/STAFF HAS MY PERMISSION TO: (Please check all that apply)

❒ Leave detailed message **at home** with my spouse

Leave detailed message **at home** with: NAME: ________________________ Relationship:__________________

❒Leave detailed message on my **cell phone** Cell phone number: ______________________

❒Leave detailed message on my **home answering machine** Home phone number: ________________________

❒Leave detailed message on my **voicemail at work** Work phone number: _________________________

In order to obtain information by telephone, the party calling Fort Wayne Chiropractic must be able to share the patient's date of birth with the staff.

____ _______________________

Signature of patient or legal guardian Date

Failed Appointment Policy

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. To cancel your appointment, please call Fort Wayne Chiropractic at (260) 492-8300. Do not cancel your appointment by replying to the text message or email reminders.

A cancellation that is not made 24 hours in advance is considered a failed appointment. Appointments are scheduled every 15 minutes. If you are 15+ minutes late arriving to your scheduled appointment, this is also considered a failed appointment. If you have 3 failed appointments during the calendar year you will incur a $25 charge.

You are responsible for any failed appointment charges that you may incur. Your insurance company does not allow this charge; therefore we will not bill your insurance.

By signing below, you understand and agree to adhere to the Fort Wayne Chiropractic Appointment Policy.

Patient Name (print) ________________________________

Patient Signature ___________________________________ **Date** _________________

DOCTOR'S LIEN

Fort Wayne Chiropractic | Gregory J. Hough, D.C.
4771 Trier Road
Fort Wayne, Indiana 46815
Telephone: (260) 492-8300
Fax: (260) 492-8301

____ ________________

Patient's Name Birthdate

____

Name of Attorney(s)

I hereby authorize Fort Wayne Chiropractic to disclose to my attorney(s) a full report of the case history, examination, diagnosis, treatment and prognosis of myself in regard to the accident in which I was involved. The purpose of this disclosure is to permit my attorney to provide me with legal services.

- This authorization has no expiration date
- I understand that I have the right to revoke this authorization by sending a written letter to Fort Wayne Chiropractic, except to the extent that Fort Wayne Chiropractic has already taken action in reliance upon this authorization.
- I understand that the information disclosed under this authorization may be redisclosed by my attorney(s) and that the privacy of my information is no longer protected by the federal privacy rule once it is disclosed to my attorney(s).
- I understand that I may inspect or copy the information to be disclosed, except in those circumstances when inspection or copying of my information may be lawfully denied under federal law.
- I also understand that I may refuse to sign this authorization, and that Fort Wayne Chiropractic will not condition treatment on my providing authorization for this disclosure.

I hereby authorize and direct you, my attorney(s), to pay directly to Fort Wayne Chiropractic such sums as may be due and owing him for professional services, supplies, items, reports, and proceedings rendered to me or on my behalf both by reason of the aforesaid accident and by reason of any other bills that are due and owing to his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate Fort Wayne Chiropractic.

I hereby give a lien on my case to Fort Wayne Chiropractic against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney(s), or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

- I full understand that I am directly and fully responsible to Fort Wayne Chiropractic for all professional bills submitted by him for services rendered to me and that this agreement is made solely for Fort Wayne Chiropractic's additional protection and in consideration of pending payment.
- I hereby waive my right to make any objections regarding the enforceability or appropriateness of this agreement. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

____ ________________

Signature of Patient Date

ATTORNEY(S): Please sign, date and return this document to the doctor's office named above. Keep a copy for your records. The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Fort Wayne Chiropractic.

____ ________________

Attorney(s) signature Date

Auto Accident Coverage Type

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Auto Accident Insurance

Insured's Name: ____________________ Date of Accident: ____________________

Claim Number: ____________________ Policy Number: ____________________

Insurance Company: ____________________

Insurance Company Address: ____________________

____

Insurance Company Telephone: ____________________ Adjusters Name: ____________________

Personal Health Insurance

Fill out this section if we will not be filing under your automobile insurance and will be filing through your personal insurance. If so, we need a copy of your insurance card(s) for our records

INSURANCE SUBSCRIBER INFORMATION: *If the subscriber is not the patient.*

Full Name ____________________ Date of birth ______/______/______

Relationship to patient ____________________ Social Security Number ____________________

Home Address ____________________ Apt # __________

City ____________________ State __________ Zip __________

Home Phone # ____________________ Cell Phone # ____________________

Attorney Information

Fill out this section if you have retained an attorney for your automobile accident claim.

Attorney Name/Firm: ____________________

Attorney Address: ____________________

Attorney Telephone: ____________________ Fax Number: ____________________

I agree that the information above is correct.

____________________ ____________________

Patient/Responsible Party Signature Date

Auto Accident Financial Policy

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

1. It is the policy of Fort Wayne Chiropractic that all services rendered are charged directly to you, the patient. Ultimately, you are responsible for the payment of all services, including those not reimbursed by third party payers.

2. The privileges of having Fort Wayne Chiropractic submit your insurance claims begin after you have provided us with complete and accurate insurance information.

3. This office does not promise that any insurance will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

4. Our office will comply with their requests to furnish the insurance company or attorney with any medical records or reports of your conditions, as long as you sign an authorization form from the insurance company or attorney to do so.

5. If you are waiting for a settlement through your attorney or from the insurance company and you still have a balance once you are in receipt of your settlement, Fort Wayne Chiropractic expects the balance to be paid in full immediately. You will be billed immediately following our notification of settlement, and if payment is not made within 30 days, the balance will be turned over to a collection agency and a 20% interest fee will be added.

6. Once your med-pay limit on your auto insurance policy has been exhausted, you will be required to provide Fort Wayne Chiropractic with your health insurance information or you will be responsible for full payment at the time of service is rendered.

7. Should you discontinue care for any reason other than being discharged by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. If payment is not made within 30 days, the balance will be turned over to a collection agency.

8. It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to a doctor-patient relationship that works for our mutual benefit.

I, ______________________________ (patient name), give Fort Wayne Chiropractic my permission to file my

claims directly to ______________________________ (insurance company name). I understand that I am

personally responsible for payment of services rendered to me for my chiropractic treatment at Fort Wayne Chiropractic.

I also authorize payment(s) to be made directly to:

Fort Wayne Chiropractic
Gregory J. Hough, DC
4771 Trier Road
Fort Wayne, IN 46815

I hereby state and agree that a photocopy will be as valid and binding as the original.

______________________________ ______________________________

Patient/Responsible Party Signature Date

Auto Accident Questionnaire

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

1. In your own words, please describe the accident: ____
____
____

2. Was the accident: ☐ vehicle vs vehicle ☐ vehicle vs object ☐ vehicle vs pedestrian

3. Your position in vehicle: ☐ driver ☐ front seat passenger ☐ right rear seat passenger ☐ left rear seat passenger ☐ rear middle seat passenger ☐ passenger in a car seat

4. What was your type of vehicle? ☐ mini car ☐ small car ☐ midsize car ☐ large size car ☐ small size SUV ☐ mid size SUV ☐ large size SUV ☐ small size pickup truck ☐ large size pickup truck ☐ very large size pickup truck ☐ tractor trailer with load ☐ tractor trailer without load

5. What size of vehicle collided with your vehicle? ☐ mini car ☐ small car ☐ midsize car ☐ large size car ☐ small size SUV ☐ mid size SUV ☐ large size SUV ☐ small size pickup truck ☐ large size pickup truck ☐ very large size pickup truck ☐ tractor trailer with load ☐ tractor trailer without load

6. Date of accident: ______________________ Time: __________ AM / PM

7. Where did the accident occur? City: _________________________________ State: __________________

8. Were you wearing a seat belt? ☐ Yes ☐ No

9. Did the air bag deploy? ☐ Yes ☐ No

10. At the time of impact were you: ☐ Looking ahead ☐ Looking over left shoulder ☐ Looking over right shoulder ☐ Looking down ☐ Looking to the left ☐ Looking to the right

11. Did any part of your body hit the interior of the vehicle? ☐ Yes ☐ No If yes, please specify what part of your body hit what part of the car: ____
____

12. Did you receive a head injury? ☐ Yes ☐ No

13. Did you lose consciousness? ☐ Yes ☐ No

14. Where was your vehicle impacted? ☐ Front right side ☐ Front left side ☐ Front center ☐ Rear right side ☐ Rear left side ☐ Rear center ☐ Rear right side ☐ Driver side ☐ Passenger side

15. Was your vehicle: ☐ Backing up ☐ Moving forward ☐ Stopped ☐ Turning left ☐ Turning right

16. What was the approximate speed of your vehicle at the time of the impact?: ____________

17. Your vehicle damage: ☐ heavy visible damage ☐ moderate visible damage ☐ slight visible damage ☐ no visible damage ☐ totaled ☐ unknown

Auto Accident Questionnaire (continued)

18. The other vehicle: ☐ Backing up ☐ Moving forward ☐ Stopped ☐ Turning left ☐ Turning right

19. What was the approximate speed of the other vehicle at the time of the impact?: ____________

20. Other vehicle's damage: ☐ heavy visible damage ☐ moderate visible damage ☐ slight visible damage ☐ no visible damage ☐ totaled ☐ unknown

21. Was your vehicle towed from the scene? ☐ Yes ☐ No

22. What were the road conditions at the time of the accident? ☐ Wet ☐ Dry ☐ Snow ☐ Ice

23. Were police at the scene? ☐ Yes ☐ No

24. Was there an accident report made? ☐ Yes ☐ No

25. Were there EMS at the scene? ☐ Yes ☐ No

26. After the accident did you: ☐ Arrange for a ride home ☐ Continue on with activities ☐ Drive self to the hospital ☐ Drive home ☐ Get transported to hospital by someone else

    If you went to the hospital, please answer the following:

    Hospital: ___________________________________ Doctor:____

    Did you have x-rays taken? ☐ Yes ☐ No

27. Have you received treatment since the accident? ☐ not treated ☐ admitted to hospital ☐ examined ☐ prescribed medication ☐ x-rays ☐ referred to another provider ☐ treated self with ice pack ☐ treated self with hot pack ☐ treated self with over the counter medication ☐ treated self with rest

28. Describe your symptoms at the time of the accident: ☐ pain ☐ache ☐annoying ☐ burning ☐ deep pain ☐ dull ☐ headache ☐ intolerable ☐ muscle spasms ☐ numbness ☐ numbness in extremities ☐ sharp ☐ shooting ☐ stabbing ☐ stiff ☐ tender ☐ throbbing ☐ tingling ☐ tingling in extremities

29. Where on your body did you feel these symptoms? ____

30. Additional symptoms at time of accident: ☐ anxiety ☐ difficulty breathing ☐ chest pain ☐ dizziness ☐ irritability ☐ loss of appetite ☐ shock ☐ Other _________________________________

31. How have symptoms changed since the accident? ☐ more pain ☐ more stiffness ☐ worsened ☐ worsened quality of life ☐ no change in daily activities ☐ improved ☐ stayed the same ☐ resolved

32. Have you lost any days of work due to your injury? ☐ Yes ☐ No

Patient Signature____ **Date** ___________________

Activities of Daily Living

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Name ________________________________ **Date** _______________

Directions: For each body area you need the doctor to treat, please choose one activity that is the most affected by your symptoms. Example is in blue in the first row

0 = none 1 = very mild 2 = discomfort 3 = tolerable 4 = distressing 5 = very distressing
6 = intense 7 = very intense 8 = horrible 9 = unbearable 10 = worst pain imaginable

Activity	Body Area Affected	Length of time before symptoms begin while doing activity	Symptom severity on a scale of 0-10 while doing activity
Walking	Lower back	10 Minutes / Hour(s)	5
Bending		Minutes / Hour(s)	
Employment duties		Minutes / Hour(s)	
Exercise/ Working out		Minutes / Hour(s)	
Household work		Minutes / Hour(s)	
Lifting		Minutes / Hour(s)	
Lying down		Minutes / Hour(s)	
Sitting		Minutes / Hour(s)	
Standing		Minutes / Hour(s)	
Walking		Minutes / Hour(s)	
Range of motion		Minutes / Hour(s)	
(other)		Minutes / Hour(s)	
(other)		Minutes / Hour(s)	

❐ No activity is affected in any way by my symptoms. My goal for treatment today is: ______________

____

Pain Assessment – Initial

Patient Name ____ **Date of Birth:** ____________________

DIRECTIONS: **Check what area of your body you want the doctor to work on, one body area per complaint box.**

Were you referred to us by another medical provider for your complaints? If yes, who? ____

Complaint #1 (main complaint)

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ____________________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ______________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ______________________________ **What makes them worse?** ____________________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ________________________________

What medical care have you received for this latest occurrence of symptoms? ____

Complaint #2

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ____________________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ______________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ______________________________ **What makes them worse?** ____________________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ________________________________

What medical care have you received for this latest occurrence of symptoms? ____

Patient Signature: ____________________________________ **Date:** ________________

Pain Assessment – Initial (page 2)

Patient Name ___________________________ **Date of Birth:** ________________

DIRECTIONS: **Check what area of your body you want the doctor to work on, one body area per complaint box. The doctor will only work on areas that you mark on this pain assessment.**

Complaint #3

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ____________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ______________________________________

What decreases your symptoms? (ex: lying down) ____________________ **What makes them worse?** ____________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ______________________

What medical care have you received for this latest occurrence of symptoms? ______________________________

Complaint #4

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious): **0 1 2 3 4 5 6 7 8 9 10**

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ____________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ______________________________________

What decreases your symptoms? (ex: lying down) ____________________ **What makes them worse?** ____________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ______________________

What medical care have you received for this latest occurrence of symptoms? ______________________________

Patient Signature: ______________________________ **Date:** ________________

Patient Health History

Fort Wayne Chiropractic

Patient Name: ______________________________________

If the question does not apply to you, check the "None" box. Please answer every question.

Health History/Review of Systems:

Musculoskeletal	**Neurological**	**Head/ENT**	**Endocrine**
❒ **NONE**	❒ **NONE**	❒ **NONE**	❒ **NONE**
❒ Muscle pain/soreness	❒ Seizures	❒ Allergies	❒ Diabetes Type 1
❒ Muscle weakness	❒ Vertigo	❒ Hearing Defect/Loss	❒ Diabetes Type 2
❒ Muscle cramps	❒ Dizziness	❒ Headaches or migraines	❒ Fatigue
❒ Muscle spasms	❒ Incoordination	❒ Ringing in ear(s	❒ Chills
❒ Joint stiffness	❒ Weak grip	❒ TMJ problems	
❒ Joint pain	❒ Paralysis	❒ Head Injury	
❒ Swollen joints	❒ Difficult speech		
❒ Low back pain	❒ Tingling		
❒ Mid back pain	❒ Loss of memory	**Cardiovascular**	
❒ Upper back pain	❒ Numbness	❒ **NONE**	
❒ Neck pain	❒ Tremors	❒ Blood Clots	
❒ Arm/Leg pain	❒ Fainting	❒ Chest pain/discomfort	
❒ Broken bones ______________	❒ Parkinsons	❒ Shortness of breath	
❒ Fractured bones ____________	❒ Concussion	❒ Heart Disease	
❒ Osteoporosis	❒ Alzheimers	❒ High Blood Pressure	
❒ Arthritis	❒ Multiple sclerosis	❒ Low Blood Pressure	
❒ Scoliosis	❒ Stroke		
❒ Fibromyalgia			
❒ Pins/screws ________________			

Medication allergies: ❒**NONE** ❒**Penicillin** ❒**Codeine** ❒**Sulfa drugs** ❒**Morphine** ❒ **Others** ______________________________

Current Medications (include dosage and frequency): ❒ **NONE**

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Past Imaging History (last 5 years) ❒ **NONE**

Date ____________ Type/Area __________________________ Results ________________________ ☐X-ray ☐MRI ☐CT

Date ____________ Type/Area __________________________ Results ________________________ ☐X-ray ☐MRI ☐CT

Past Hospitalization/Surgical History (last 5 years) ❒ **NONE**

Date ___________ Reason/Type of surgery ________________________ Hospital _____________ ☐ Surgery ☐ Hospitalization

Date ___________ Reason/Type of surgery ________________________ Hospital _____________ ☐ Surgery ☐ Hospitalization

Date ___________ Reason/Type of surgery ________________________ Hospital _____________ ☐ Surgery ☐ Hospitalization

Biological Family History (ex: father-diabetes): ❒ **NONE** ____

Work Habits: _____ Hours per week ☐retired ☐homemaker ☐student ☐unemployed ☐disabled ☐ light labor ☐ moderate labor ☐ heavy labor ☐ repetitive ☐ computer ☐mostly sitting ☐mostly standing ☐mostly walking ☐difficult ☐stressful

Social habits: ☐ Every day smoker ☐ Some day smoker ☐ Heavy tobacco use ☐ Light tobacco use ☐ Former Smoker ☐ Never smoked ☐ More than 6 caffeine drinks a day ☐ 3-6 caffeine drinks a day ☐ Less than 3 caffeine drinks a day ☐ No caffeine drinks a day

Exercise: ☐ Weekly ☐ Daily ☐ None

Patient Signature: ____ **Date**: ______________