Healing Hands Chiropractic

Dr. Megan Cloud, D.C.

Patient Information

Thank you for choosing our practice for your chiropractic needs.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name: (First) _____ (Last) _____

Date: _____ I would like to be called: _____

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

Phone: Home: _____ Work: _____ Cell: _____

Birthdate: _____ Age: _____Height: _____ Weight: _____ Social Security #:_____

Are you? □ Male □ Female □ Married □ Single □ Widowed □ Divorced □ Separated

□ African American □ Asian □ Caucasian □ Hispanic □ Other

Do you have children? □ Yes □ No Ages: _____

Your Employer: _____ Occupation: _____

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

Spouse's or Parent's Name: _____ Workplace: _____ Work Phone: _____

Whom may we thank for referring you to us? _____

Symptoms

Reason for visit: _____

When did your problem begin?_____

Did it begin □ suddenly □ gradually □ progressively over time

Did it start from an injury: □ Yes □ No what happened? _____

Is this condition getting: □ Better □ Worse □ staying the same

Have you experienced a similar problem before? _____

Where specifically is the problem(s) located? _____

Type of pain: □ Dull □ Sharp □ Aching □ Shooting □ Spasm □ Throbbing

□ Burning □ Numbness □ Tingling

Rate the severity of your pain (1 – no pain or discomfort to 10 – severe pain):

0 1 2 3 4 5 6 7 8 9 10

Is the pain constant? _____

What makes it better? _____

What makes it worse? _____

What treatment have you already received for your condition? _____

□ Medication □ Surgery □ Physical Therapy □ Chiropractic □ Other_____

Name and address of other practitioner(s) who have treated you for your condition: _____

_____

Other areas of concern: _____

_____

_____

Health History

Check conditions that apply

□ Abnormal Weight Loss	□ Bronchitis	□ Gout	□ Osteoarthritis
□ Abnormal Weight Gain	□ Cancer, Type: _____	□ Heart Disease	□ Osteoporosis
□ AIDS/HIV	□ Depression	□ High Blood Pressure	□ Pacemaker
□ Alcoholism	□ Diabetes	□ High Cholesterol	□ Restless Leg Syndrome
□ Anemia	□ Disc Disorder	□ Jaw Pain	□ Rheumatoid Arthritis
□ Anxiety	□ Dizziness	□ Kidney Disorder	□ Scoliosis
□ Asthma	□ Fatigue	□ Lyme Disease	□ Stroke
□ Back Pain	□ Fibromyalgia	□ Menstrual Pain	□ Thyroid Disease
□ Bladder Infection	□ Frequent Urination	□ Migraine Headaches	

Other: _____

Date of last medical exam? _____ Who did you see? _____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No

List any surgeries you have had and any times you have been hospitalized (include dates):

_____

_____

List any accidents or injuries and the dates they occurred (include broken bones):

_____

_____

Please list all medications that you are currently taking and the reasons:

_____

_____

Have you ever been seen by a chiropractor before? □ Yes □ No When? _____

For what condition? _____

Family History

Does anyone in your family have a condition similar to yours? □Yes □ No Who? _____

Does anyone in your family have?

□ Arthritis, Type: _____	□ Back Pain	□ Diabetes	□ Disc Disorders
□ Cancer, Type: _____	□ Heart Disease	□ High Blood Pressure	□ Neck Pain
□ Headache, Type: _____	□ Scoliosis	□ Stroke	

Daily Habits

What type of exercise do you perform? _____

What do your daily work habits include (i.e.: sitting, standing, light labor, heavy labor, computer work):

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? □ Yes (How many packs per day? _____) □ Never Smoker □ Former Smoker

How much alcohol do you consume per day? _____ Caffeinated Beverages? _____

Authorization

I certify that I have read and understand, and answered the above information to the best of my knowledge. I authorize Dr. Cloud to perform a chiropractic evaluation, and if appropriate, treatments for my condition. I authorize Healing Hands Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Healing Hands Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

Signature of Patient (or parent if a minor) Date