Patient #: _____

HOGUE CHIROPRACTIC CENTER

First Name: _____ Middle Initial: _____ Last Name: _____

Do you prefer to go by another name or nickname? _____

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

Date of Birth: _____ Age: _____ Social Security #: _____

Please Circle: Male / Female Please Circle: Single / Married / Widowed / Divorced

Home #: _____ Cell #: _____ Work #: _____

Emergency Contact Name: _____ Emergency Contact #: _____

Email Address: _____ Who referred you to us? _____

Employer: _____ Occupation: _____

Physician's Name and Address: _____

Health Insurance Information:

*****PLEASE BE ADVISED THAT WE ARE OUT OF NETWORK WITH ALL MEDICAID PLANS AND ALL CIGNA PLANS*****

Insurance Company: _____ Are you covered as Self, Spouse or Child? _____

Main Policy Holder's Name: _____ Main Policy Holder's Date of Birth: _____

Insurance ID #: _____ Insurance Group #: _____

FINANCIAL AGREEMENT

I authorize the use of this information for insurance billing. I authorize the release of information to the insurance company. I understand that I am responsible for my charges for services. I authorize payment to Hogue Chiropractic Center. I permit a copy of this authorization to be used in place of the original.

Sign: _____ Date: _____

Name: _____ **Date:** _____

Please list your chief complaints: _____

_____

Please circle what best describes your symptoms: **Mild / Moderate / Severe**

What worsens your symptoms? _____

What makes your symptoms better? _____

How long have your symptoms been present? _____

Please circle how your symptoms started: **Suddenly / Gradually / Long-standing problem**

Please circle what best describes your symptoms: **Constant / Progressive / Intermittent**

Have you had the same or similar symptoms in the past? _____

Have you had prior treatment or testing for this problem? _____

Are your symptoms due to a recent injury? _____ **Date of injury:** _____

If so, please circle type of injury: **Auto Accident / Personal Injury / Workers Compensation**

Please describe your accident or injury: _____

Have you had any past injuries? _____

Please list the year and type of injury: _____

Do your symptoms interfere with: Daily living? Y / N Sleep? Y / N Lifestyle? Y / N Work? Y / N

Have you missed work due to this problem: _____

Please list all of your current medications: _____

_____

Please list all surgeries you've ever had (including breast implants): _____

_____

Have you had any significant past illnesses? _____

Do you have any family history of illness (Ex. Diabetes, High Blood Pressure)? _____

_____

Father's Age: _____ Living / Deceased Cause of Death: _____

Mother's Age: _____ Living / Deceased Cause of Death: _____

Please describe your Alcohol usage: _____

Please describe your Tobacco usage: _____

Do you exercise? _____ Types of exercise: _____

Number of children? _____ Women: Is there any chance you are currently pregnant? _____

Please circle the conditions that best describe your work environment:

Loud / Lung Pollutant / Extreme Hot/Cold / Constant Sitting / Constant Standing / Lifting

Heavy Data Entry / Stressful / No Problems

Have you experienced any recent traumas (Ex. Divorce, Death of Family/Friend, Loss of Job)? _____

_____

Have you been treated by a chiropractor before? _____ Name of chiropractor: _____

Were your results satisfactory? _____

Please circle each condition you have recently experienced:

Fatigue Joint Pain Headaches Stiff Neck Inflammation Numbness Scoliosis

Muscle Ache Muscle Cramps Muscle Spasm Muscle Weakness Tenderness Stiffness

Arthritis Abnormal Posture Fracture/Dislocation Bladder Infection Diarrhea Constipation

Recent Trauma Sprain Menstrual Problems Numbness in Legs Nervousness Irritability

Sleep Disorder Short of Breath High Blood Pressure Depression Tension Loss of Memory

Loss of Balance Loss of Taste/Smell

Have you been diagnosed with HIV/Aids or Hepatitis? _____

If yes, please tell us which type of hepatitis and year of diagnosis: _____

Pain Chart

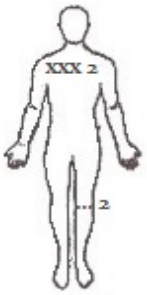
Please rate the severity of pain you have generally felt over the past few days by circling one box on the pain scale below.

(0 = No pain 10 = Excruciating pain)

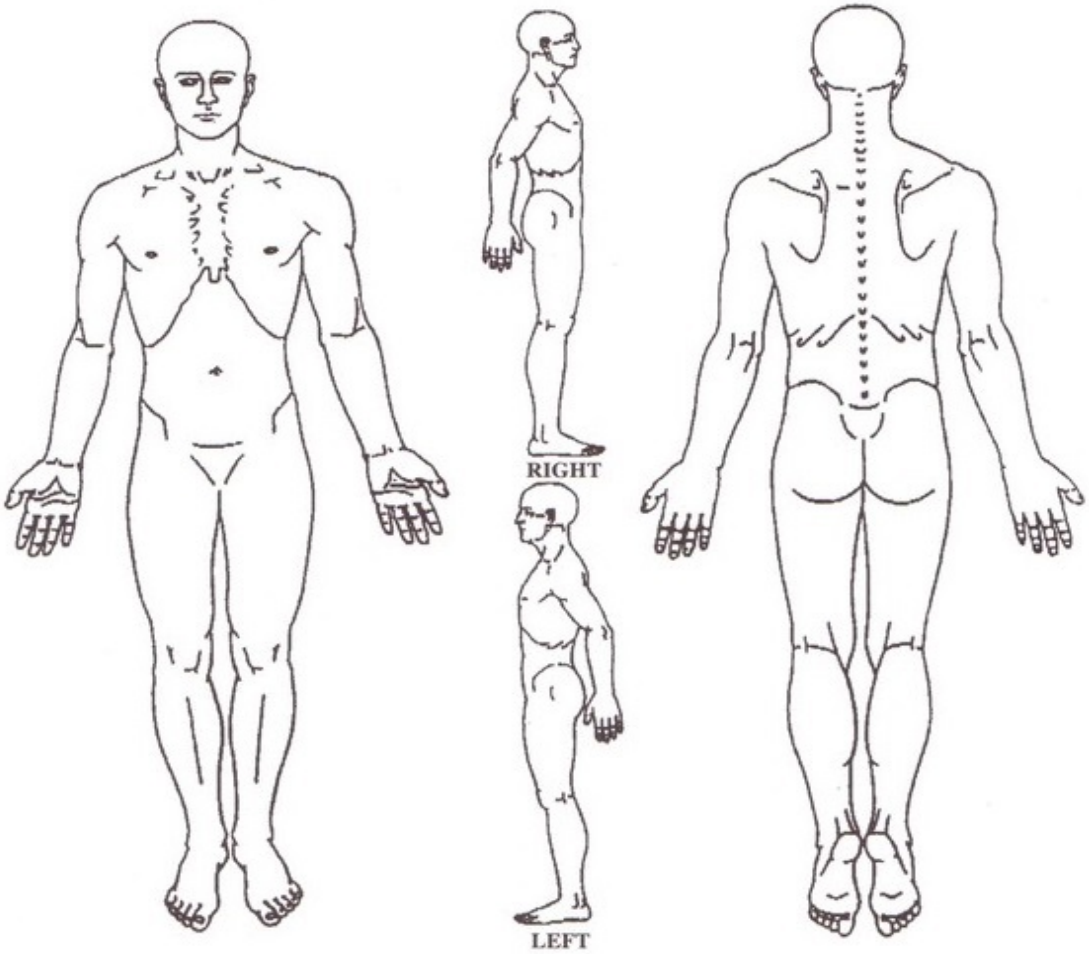
0	1	2	3	4	5	6	7	8	9	10

Please mark areas of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) through 10 (extreme pain).

Pain = PPP Numbness = --- Pins & Needles = ooo Burning = ^^^ Aching = xxx Stabbing = …



Example



I have read the information in this packet and I have anwered to the best of my ability.

Sign: _____ **Date:** _____