HANCOCK HOLISTIC CLINIC

DEPENDENT PATIENT HISTORY FORM

Information you provide here is privileged and confidential. Your privacy will be respected.

Date: ____________________

Dependent's Name: _________________ Middle Initial: _______ Last Name: _______________________

Address: ____

City/State/Zip: ____

Sex: ________ Age: _____ Birthdate: _____/_____/_______ Height: _________ Weight: __________

Parent / Guardian Information

Name _____________________________ Relationship to dependent: ___________________

Phones - Home: ______________ Work: __________________ Cell: ____________________

Occupation: __________________________ Marital Status: ____________ Children: ______

Employer: _______________________ Work site – City / State: _________________________

Name of Spouse or Significant Other: ____

Their Employer: ______________________ Work site – City / State: ____________________

How did you learn about our clinic? ____

General health: ____

Which of the following "Complementary" health care therapies has dependent utilized? (please circle)

Massage/Bodywork Chiropractic Nutritional Acupuncture Homeopathic Naturopathic

Other: ____

Describe the health care reason for which the dependent came to see us: _________________________

____

When did this start and/or how did this develop? ____

Other Professionals seen for this problem: ____

Diagnosis, if known, and current treatment: ____

Describe the results from previous treatments for this condition: _________________________________

____

Activities/tasks/movements which the dependent is unable to perform, or which cause or increase problems:

____

School or work dependent missed due to the presenting problem noted above:

List ALL surgeries (with year they occurred): ____

____ (cont. on back of page if necessary)

Is the dependent currently under a physician's care? Yes No If yes, please explain:

Name of Dependent: ______________________________ Date: ____________________________

FALLS, AUTO ACCIDENTS & OTHER TRAUMAS

DATE OF TRAUMA: _________________ **DESCRIBE EVENT**: ________________________________

____

____

DESCRIBE DEPENDENT's INJURIES: ____

____

MEDICAL TREATMENT RECEIVED: ____

____

CURRENT SYMPTOMS ASSOCIATED WITH THIS TRAUMA: _________________________________

____

DATE OF TRAUMA: _________________ **DESCRIBE EVENT**: ________________________________

____

____

DESCRIBE DEPENDENT's INJURIES: ____

____

MEDICAL TREATMENT RECEIVED: ____

____

CURRENT SYMPTOMS ASSOCIATED WITH THIS TRAUMA: _________________________________

____

DATE OF TRAUMA: _________________ **DESCRIBE EVENT**: ________________________________

____

____

DESCRIBE DEPENDENT's INJURIES: ____

____

MEDICAL TREATMENT RECEIVED: ____

____

CURRENT SYMPTOMS ASSOCIATED WITH THIS TRAUMA: _________________________________

____

Name of Dependent: ___________________________________ **Date:** _____________________

Describe any skin disorders: ____

List any known sensitivities or allergies: ____

Does the dependent have ANY OTHER medical condition or physical limitation that we as health care providers may need to be aware of before he/she receives therapy? (please explain):

Are there any known emotional issues relating to bodywork or touch? Yes Uncertain No

Current prescriptions, vitamins, minerals and over-the-counter medications: _ ______________________

____

Does Dependent ….

Regularly drink caffeinated beverages? (sodas or energy drinks / tea / coffee) No Yes
How much? ___________

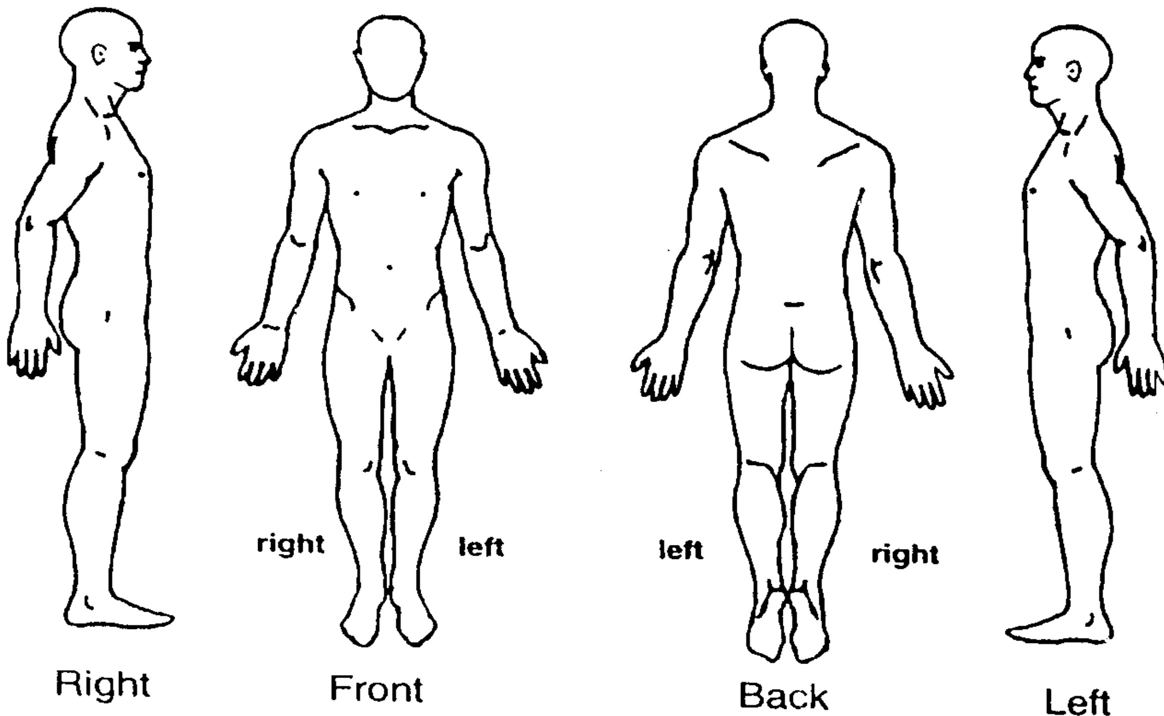
Regularly drink "diet" beverages or use artificial sweeteners? ___________ How much? ___________

Drink alcoholic beverages? No Yes __________ Use tobacco? No Yes ___________

Does dependent engage in sports / physical-fitness type activity on a regular basis? Yes No

If any, please describe: ____

Please **shade in** clearly **ALL areas** where dependent has frequent or occasional pain or problem:



Name of Dependent: _______________________________________ **Date:** _______________________

Please check all of the following that now apply or have applied to you:

System-wide:

- ❑ Broken bones
- ❑ Cancer
- ❑ Diabetes
- ❑ Fatigue
- ❑ Sleep problems
- ❑ Food / Diet / Eating Concerns
- ❑ Weight concerns thin / heavy

Allergies/Sensitivities:

- ❑ Medications
- ❑ Foods/additives
- ❑ Chemicals/fragrances

Back/Buttocks/Hips/Pelvis:

- ❑ Spinal deformity / damage
- ❑ Lower back pain
- ❑ Mid back pain
- ❑ Upper back pain
- ❑ Hip pain
- ❑ Coccyx (tail-bone) pain

Balance/Ears/Eyes:

- ❑ Dizziness
- ❑ Falls/loss of balance
- ❑ 'Accident-prone'
- ❑ Ear infections – frequent
- ❑ Ear-aches
- ❑ Tubes in ears
- ❑ Ears 'ring', 'hum', throb
- ❑ Hearing Concerns
- ❑ Hearing aid
- ❑ Eye pain
- ❑ Glasses or Contacts
- ❑ Eye surgeries
- ❑ Other vision Concerns

Circulation/Blood/Veins:

- ❑ Anemia (low iron)
- ❑ Blood sugar -- High Low
- ❑ Fainting
- ❑ Heart abnormality

Chest/Breathing/Ribs:

- ❑ Asthma
- ❑ Pain with deep breath

Development Concerns:

- ❑ PDD (Developmental Disorder)
- ❑ Sexual Development concerns
- ❑ Urinary / Bowel Control
- ❑ Females – Menstrual Problems

Emotional & Relationships:

- ❑ Anger/Hostility issues
- ❑ Clingy
- ❑ Withdrawn or Depression
- ❑ Significant irritability
- ❑ 'Mood swings'
- ❑ Issues with being touched
- ❑ Peer Relationship Concerns
- ❑ Family Relationship Concerns

Head/Brain/Neck/Throat:

- ❑ Headaches
- ❑ Brain feels 'in a fog' - thinking Is 'fuzzy' or 'poorly connected'
- ❑ Neck pain
- ❑ 'Stiff neck' or restricted movement
- ❑ Sinusitis
- ❑ Other nasal problems
- ❑ Seizures
- ❑ Scalp pain and/or scalp problems
- ❑ Throat / Voice problems or pain
- ❑ Whiplash

Internal Organs:

- ❑ Constipation
- ❑ Diarrhea
- ❑ Intestinal problems
- ❑ Stomach problems
- ❑ Other internal problems
- ❑ GERD (Acid Reflux)

Lower Limbs - Legs/Knees/Ankles/Feet:

- ❑ Knee pain
- ❑ Leg pain
- ❑ Feet hurt
- ❑ Feet cold
- ❑ Feet numb or 'tingle-y'
- ❑ Sciatica

Oral/TMJ:

- ❑ TMJ problems
- ❑ Teeth or bite problems
- ❑ Orthodontics (Braces)
- ❑ Mouth/jaw pain
- ❑ 'Clicking' / 'Popping' in jaws

Posture:

- ❑ Scoliosis
- ❑ 'Stoop-shouldered'
- ❑ 'Bad posture'

Skin:

- ❑ Rashes
- ❑ Unexplained redness
- ❑ Skin diseases, etc.
- ❑ Fungus infections
- ❑ Skin Problems / Acne

Upper Limbs - Shoulders/Arms/ Wrists/Hands

- ❑ Shoulder pain
- ❑ Elbow pain
- ❑ Wrist pain
- ❑ Hands cold
- ❑ Hands hurt
- ❑ Hands numb or 'tingle-y'

Name of Dependent: ______________________________________ **Date:** __________________

Birthdate: _____/_____/__________

I have listed all of this dependent's known medical conditions and physical limitations, and I will inform this provider of any changes in his / her physical health. I understand that a licensed health care provider who is treating this dependent's must be aware of all existing physical conditions that exist in order to provide appropriate and informed care.

I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

____ ____________________

Signature Date

____

Name (please print)

I understand the information contained herein is privileged and confidential, and at this time I authorize the release of any information pertaining to this dependent's health to his/her attorney, insurance company, and/or referring physician(s) or therapist(s). Furthermore, I authorize the above persons to release any pertinent information about him/her if needed, to this provider. I understand that this information will be treated as privileged and confidential.

____ ____________________

Signature Date

____

Name (please print)

Name of Dependent: ____ **Date:** _____________________

Birthdate: _____/_____/__________

As responsible health care providers, the following health-related factors are important for us to know so we can provide this dependent with the most appropriate and most effective care. Some of these factors also affect the precautions that our clinic must take to minimize the risks of spreading contagious conditions. In accordance with current laws and HIPAA, these healthcare concerns are considered **HIGHEST CONFIDENTIALITY TOPICS.**

Therefore, this page is NOT released to other health care providers, insurers, OR any other entity <u>except</u> by court order. *Thank you for your trust.*

- ❑ Drug Abuse
  - ❑ Alcohol (please check: ___ past ___ present ___suspected)
  - ❑ Street Drugs (please check: ___ past ___ present ___suspected)

    Which drugs? ____
  - ❑ Prescription Abuse (please check: ___ past ___ present ___ suspected)

    Which drugs? ____

- ❑ Abuse Survivor
  - ❑ Physical (please check: ___ past ___ present ___suspected)
  - ❑ Emotional (please check: ___ past ___ present ___suspected)

- ❑ Contagious Diseases
  - ❑ AIDS
  - ❑ HIV
  - ❑ STD(s) ___________________________ (please check: ___ past ___ present ___unknown)
  - ❑ Hepatitis - Type _____ (please check: ___ past ___ present)
- ❑ _____________________________________
- ❑ _____________________________________

____

Dependent's Name

____ ____________________

Signature of Parent or Guardian Date

____

Name (please print) of Signature of Parent or Guardian