HANCOCK HOLISTIC CLINIC
PATIENT HISTORY FORM
Information you provide here is privileged and confidential. Your privacy will be respected.

Date: _____

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

Address: _____

City/State/Zip: _____

Phones - Home: _____ Work: _____ Cell: _____

Birthdate: _____/_____/_____ Sex: _____ Marital Status: _____ # of children _____

Occupation: _____ Employer: _____

Work Site - City/State/Zip: _____

Name of Spouse or "Significant Other": _____

Their Employer: _____ Work Phone: _____

Work Site - City/State/Zip: _____

Who referred you to us? _____

****

Height: _____ Weight: _____ Age: _____ General health: _____

Which of the following "Complementary" health care therapies have you utilized? (please circle)

Massage/Bodywork Chiropractic Nutritional Acupuncture Homeopathic Naturopathic

Other: _____

Describe the health care reason for which you 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 you are unable to perform, or which cause or increase pain:

_____

Work missed due to the presenting problem noted above: _____

List ALL surgeries (with year they occurred): _____

_____ (cont. on back of page if necessary)

Are you currently under a physician's care? Yes No If yes, please explain: _____

_____

_____

Name: _____ **Date:** _____

ACCIDENT REPORT

AUTO, FALL OR OTHER

DATE OF ACCIDENT: _____ DESCRIBE ACCIDENT: _____

_____

_____

DESCRIBE YOUR INJURIES: _____

_____

MEDICAL TREATMENT RECEIVED: _____

_____

CURRENT SYMPTOMS ASSOCIATED WITH THIS ACCIDENT: _____

_____

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DATE OF ACCIDENT: _____ DESCRIBE ACCIDENT: _____

_____

_____

DESCRIBE YOUR INJURIES: _____

_____

MEDICAL TREATMENT RECEIVED: _____

_____

CURRENT SYMPTOMS ASSOCIATED WITH THIS ACCIDENT: _____

_____

++

DATE OF ACCIDENT: _____ DESCRIBE ACCIDENT: _____

_____

_____

DESCRIBE YOUR INJURIES: _____

_____

MEDICAL TREATMENT RECEIVED: _____

_____

CURRENT SYMPTOMS ASSOCIATED WITH THIS ACCIDENT: _____

_____

Name: _____ Date: _____

Please list prescriptions used and their purpose: _____ (cont. on back)

Please list other medications/supplements: _____ (cont. on back)

Have you had any serious illnesses in the past 3 years? Yes No If yes, please explain:

_____

Do you have any skin disorders or allergies? Please list: _____

_____

Do you regularly drink caffeine beverages (coffee, tea, soda, etc.)? Yes No How much? _____

Do you use tobacco? Yes No How many packs a day? _____

Do you drink alcoholic beverages? Yes No If yes, how much? _____

Women: Are you pregnant? Yes No If yes, what is the estimated due date? _____

Have you been engaging in any physical-fitness-type activity on a regular basis? Yes No

Please describe: _____

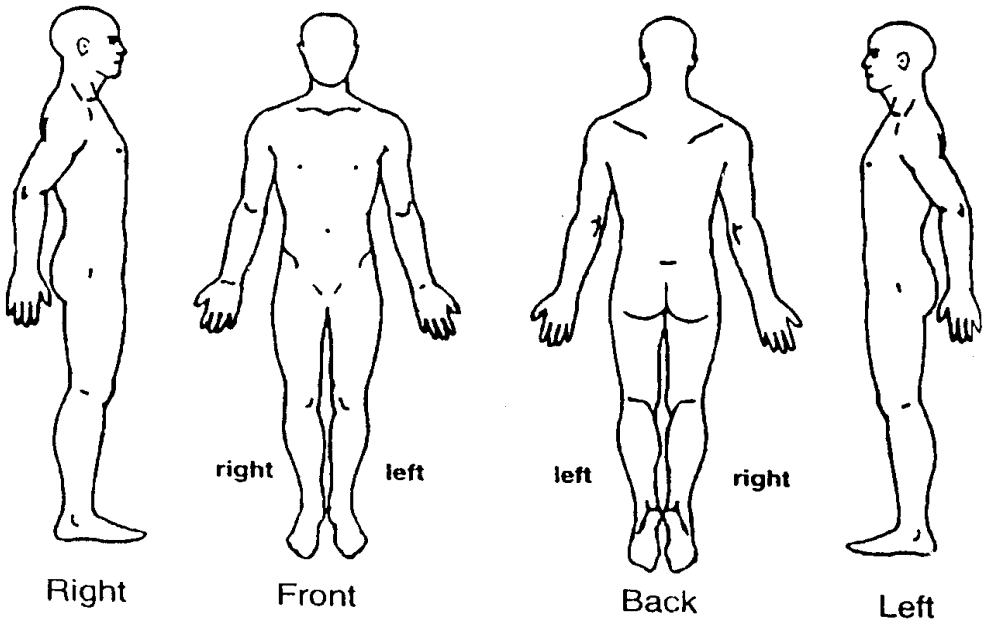
Do you have ANY OTHER medical condition or physical limitation that we as health care providers may need to be aware of before you receive treatment? Yes No If yes, please describe: _____

_____

Do you have any emotional issues relating to bodywork or touch? Yes Uncertain No

If yes or uncertain, please describe: _____

Please **shade in** clearly **ALL areas** where you have frequent or occasional pain:



Name: _____ Date: _____

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

System-wide Dysfunctions:
- ❑ Arthritis
- ❑ Broken bones
- ❑ Cancer
- ❑ Diabetes
- ❑ Edema (swelling)
- ❑ Fatigue
- ❑ Fibromyalgia Syndrome
- ❑ Joints inflamed
- ❑ Osteoporosis
- ❑ Sleep problems
- ❑ Tremors/'Shakes'

Allergies/Sensitivities:
- ❑ Medications
- ❑ Foods/additives
- ❑ Chemicals/fragrances

Back/Buttocks/Hips/Pelvis:
- ❑ Lower back pain
- ❑ Mid back pain
- ❑ Upper back pain
- ❑ Herniated or ruptured disks
- ❑ Hip pain
- ❑ Coccyx (tail-bone) pain

Balance/Ears/Eyes:
- ❑ Dizziness
- ❑ Falls/loss of balance
- ❑ 'Accident-prone'
- ❑ Ear-aches
- ❑ Ear infections - frequent
- ❑ Tubes in ears
- ❑ Ears 'ring', 'hum', etc.
- ❑ Hearing problems
- ❑ Hearing aid
- ❑ Eye pain
- ❑ Glasses or contacts
- ❑ Eye surgeries
- ❑ Other vision problems

Circulation/Blood/Veins:
- ❑ Anemia (low iron)
- ❑ Blood sugar -- High Low
- ❑ Blood clots
- ❑ Fainting
- ❑ Blood pressure -- High Low
- ❑ Heart surgeries
- ❑ Other circulatory problems
- ❑ Varicose veins
- ❑ Vein Surgery
- ❑ Stroke

Chest/Breathing/Ribs:
- ❑ Asthma
- ❑ Chest pain
- ❑ Pain with a deep breath
- ❑ Shortness of breath

Emotional Issues:
- ❑ Anger/Hostility issues
- ❑ Dependency issues
- ❑ Significant depression
- ❑ Significant irritability
- ❑ 'Mood swings'
- ❑ Issues with being touched

Female concerns:
- ❑ Breast problems (any kind)
- ❑ Difficult pregnancies/births
- ❑ Fertility concerns
- ❑ PMS - significant problems
- ❑ Strong menstrual cramps

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:
- ❑ Abdominal hernia
- ❑ Constipation
- ❑ Diarrhea
- ❑ Intestinal problems
- ❑ Kidney problems
- ❑ Liver
- ❑ Stomach problems
- ❑ Other internal organ problems

Lower Limbs - Legs/Knees/Ankles/Feet:
- ❑ Knee pain
- ❑ Leg pain
- ❑ Feet hurt
- ❑ Feet cold
- ❑ Feet numb or 'tingle-y'
- ❑ Sciatica

Male Concerns:
- ❑ Prostate concerns
- ❑ Performance concerns
- ❑ Testicle concerns
- ❑ Difficulties with urinating

Oral/TMJ:
- ❑ TMJ problems
- ❑ Teeth or bite problems
- ❑ Mouth/jaw pain
- ❑ 'Clicking'/'Popping' in jaws

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

Skin:
- ❑ Rashes
- ❑ Unexplained redness
- ❑ Skin diseases, etc.
- ❑ Fungus infections

Upper Limbs - Shoulders/Arms/ Wrists/Hands
- ❑ Bursitis
- ❑ Carpal Tunnel (syndrome or surgery)
- ❑ Shoulder pain
- ❑ Elbow pain
- ❑ Wrist pain
- ❑ Hands cold
- ❑ Hands hurt
- ❑ Hands numb or 'tingle-y'

Name: _____ Date: _____

Birthdate: _____/_____/_____

I have listed all of my known medical conditions and physical limitations, and I will inform this provider of any changes in my physical health. I understand that a licensed health care provider who is treating me must be aware of all existing physical conditions that I have 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 my health to my attorney, insurance company, and/or referring physician(s) or therapist(s). Furthermore, I authorize the above persons to release any pertinent information about me, if needed, to this provider. I understand that this information will be treated as privileged and confidential.

_____ _____

Signature Date

_____

Name (please print)

Name: _____ **Date:** _____

Birthdate: _____/_____/_____

As responsible health care providers, the following health-related factors are important for us to know so we can provide you 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)
  - ❑ Street Drugs (please check: ___ past ___ present)
    Which drugs? _____
  - ❑ Prescriptions (please check: ___ past ___ present)
    Which drugs? _____

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

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

- ❑ _____
- ❑ _____
- ❑ _____

_____ _____
Signature Date

_____
Name (please print)