CONFIDENTIAL PATIENT APPLICATION FOR CARE

Welcome to our practice! Please complete all questions. Thank you. [Please Print]

Patient Name:_____ Date:_____/_____/_____ Account #_____

If patient is considered a minor or is under 18 years of age, parent or legal guardian must sign to accept responsibility and complete form.

Responsible party name:_____ Signature:_____

Address:_____ Home Phone:_____

City:_____, State:_____,Zip:_____ Cell Phone:_____

Date of Birth: _____/_____/_____ Age:_____ Gender: Male Female Marital Status: M W D S

Social Security #:_____ Spouse's Name:_____

E-Mail Address:_____ Work Phone:_____

Employed By:_____ Address:_____

Emergency Contact:_____ PH#_____ Cell#_____

Whom may we Thank for referring you to our clinic:_____

How many children do you have? _____ What are their Names/Ages? _____

_____

Have they or any other members of your family received chiropractic care? [ ] Yes [ ] No Whom: _____

Have you ever had chiropractic care? [ ] Yes [ ] No if so when: _____

List your purpose or reason for this appointment:

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

Does the pain spread? [ ] Yes [ ] No If yes, where?_____
Is there pain when you cough or sneeze? [ ] Yes [ ] No If yes, where?_____
Is there pain when you go from a sit to a stand? [ ] Yes [ ] No If yes, where?_____
Do you have headaches? [ ] Yes [ ] No If yes, check all that apply? [ ] Tension [ ] Throb [ ] Sinus [ ] Migraine

Indicate any function below that aggravate or are aggravated by your condition: (Check all that apply)
[ ] Walking [ ] Step Climbing [ ] Driving [ ] Working [ ] Recreation [ ] Bowel Movements [ ] Vision [ ] Digestion [ ] Breathing
[ ] Sinuses [ ] Hearing [ ] Smelling [ ] Sleeping [ ] If female, Menstrual

Have you ever suffered from or been diagnosed as having: (circle Yes or No for each)

Y N Broken or Fractured Bones	Y N Drug Addiction	Y N Ulcers
Y N Osteoarthritis	Y N Seizures/Convulsions	Y N Head Problems
Y N Eating Disorder	Y N Strokes	Y N High/Low Blood Pressure
Y N Circulatory Problems	Y N HIV Positive	Y N Ruptures
Y N Epilepsy	Y N A Congenital Disease	Y N Depression
Y N Alcoholism	Y N Cancer	Y N Diabetes
Y N Rheumatoid Arthritis	Y N Gall Bladder	Y N Coughing Blood
Y N Pacemaker	Y N Excessive Bleeding	Y N Tumors

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., TB, Hepatitis.

CHECK ANY THE FOLLOWING SYMPTOMS YOU HAVE HAD DURING THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing
- ☐ Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion /Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems /Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

Other Problems_____

_____

_____

FEMALES ONLY:

When was your last period?_____

Are you pregnant? ( ) Yes ( ) No ( ) Unsure

t What are your goals for your health?

[ ] None

[ ] Maintain good health

[ ] Get rid of symptoms only

What brings you through the door? _____

_____

What is your expectation? _____

_____

FAMILY HISTORY

The following members have the same or similar problems I do:

( ) Mother ( ) Father ( ) Brother

( ) Sister ( ) Spouse ( ) Child

Other:_____

For CA's use only

TOTAL NUMBER OF LISTED SYMPTOMS

_____

How often do you drink alcoholic beverages? _____

Do you smoke [ ] Yes [ ] No if so how much: _____

Do you exercise [ ] Yes [ ] No if so how often: _____

Do you have any Allergies? (Specify): _____

Medication List

Medication	Vitamins	Non-Rx Strength	Rx Strength	Date Started	Date Ended	Prescribed by Whom

Please Identify all facilities/providers you have seen for these conditions and those you currently are seeing. If an, for your presenting problem(s)

Problem List

Dr Name/Facility	Problem	Type of Treatment Received	From Whom and When

Medical Information Release Information (HIPAA Release Form)

[ ] I authorize Dr. Hannouche to provide treatment for my condition(s) found through examination and/or x-rays related to vertebral subluxation.

[ ] I authorize Hannouche family Chiropractic to to contact me via [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is [ ] Day time between the hours of _____ and _____

[ ] I authorize the release of information including the diagnosis, records and examination results rendered to me and claims information to me my insurance company if requested as well as any per son listed below:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Release no information without my [ ] written [ ] verbal consent.

CHECK ANY THE FOLLOWING SYMPTOMS ANYONE IN YOUR FAMILY HAS HAD DURING THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___Children
  - ___Siblings
- ☐ Pain Between Shoulders
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___Children
  - ___Siblings
- ☐ Neck Pain
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Arm Pain
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Joint Pain/Stiffness
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Walking Problems
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Clicking Jaw
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings

NERVOUS SYSTEM

- ☐ Nervous
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Numbness
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Paralysis
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Fainting
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Convulsions
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Cold/Tingling Extremities
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings

GENERAL

- ☐ Fatigue
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Allergies
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Headaches
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings

GASTRO-INTESTINAL

- ☐ Excessive Thirst
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Frequent Nausea
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Vomiting
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Diarrhea
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Constipation
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Liver Problems
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Gall Bladder Problems
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Weight Trouble
  - ___ Mother
  - ___Father
  - ___Spouse
  - ___ Children
  - ___Siblings
- ☐ Heartburn
  - ___ Mother
  - ___Father

___Spouse
___ Children
___Siblings

☐ Colitis
___ Mother
___Father
___Spouse
___ Children
___Siblings

GENITO-URINARY

☐ Bladder Trouble
___ Mother
___Father
___Spouse
___ Children
___Siblings

C-V-R

☐ Chest Pain
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Short Breath
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Blood Pressure Problems
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Heart Problems
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Lung Problems /Congestion
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Ankle Swelling
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Stroke
___ Mother
___Father
___Spouse
___ Children
___Siblings

EENT

☐ Sore Throat
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Ear Aches
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Hearing Difficulty
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Stuffed Nose
___ Mother
___Father
___Spouse
___ Children
___Siblings

MALE/FEMALE

☐ Menstrual Irregularity
___ Mother
___Spouse
___ Children
___Siblings

☐ Menstrual Cramps
___ Mother
___Spouse
___ Children
___Siblings

☐ Vaginal
___ Mother
___Spouse
___ Children
___Siblings

☐ Pain/Infections
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Breast Pain/Lumps
___ Mother
___Father
___Spouse
___ Children
___Siblings

☐ Prostate/Sexual Dysfunction
___Father
___Spouse
___ Children
___Siblings

Other Problems_____
_____
_____

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____