

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 age 18 parent a legal guardian must sign to accept responsibility and complete form:

Responsible Party Name: _____ Signature _____

Address: _____ Home Phone _____

City: _____ State: _____ Zip: _____ Cell: _____

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

Social Security # _____ - _____ - _____ Spouse's Name: _____

Email: _____ Work Ph: _____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Ph: _____ Cell: _____

Whom may we thank for referring you to our clinic? _____

List your reason(s) for this appointment:

1. _____ How Long? _____

2. _____ How Long? _____

3. _____ How Long? _____

Does the pain spread (radiate)? 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 sit to stand? Yes No If yes, where? _____

Do you have headaches? Yes No If yes, check all that apply: Tension Throbbing Sinus Migraine

Indicate any function below that aggravates, or is aggravated by, your condition: (check all that apply)

Walking Step Climbing Driving Working Recreation Bowel Movements

Sinuses Digestion Breathing Hearing Vision Smelling Sleeping 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 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 OF THE FOLLOWING SYMPTOMS YOU'VE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

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

NERVOUS SYSTEM

- Nervousness
- Numbness
- Paralysis
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsion
- Cold/Tingling Extremities
- Stress

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urination

GENERAL

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

GENITO-URINARY

- 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 Stools

C V R (Chest Heart Lungs)

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

EENT (Eyes Ears Nose Throat)

- Vision Problems
- Dental Problems
- Sore Throat
- Earaches
- Hearing Difficulty
- Stuffy Nose

MALE / FEMALE

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

Date of Last Period: _____

Are you Pregnant? Y N Unsure

FAMILY HISTORY:

The following members have the same or similar problems I have: (Circle any that apply):

Mother Father Sister Brother Spouse Child Other: _____

What are your goals for your health? _____

What brings you through our door today? _____

What are your expectations? _____

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? (Please specify): _____

MEDICATION LIST:

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

➔ Any vaccinations or boosters taken in the last 6 months (Specify): _____
 Have you received a Covid-19 Vaccination? Yes No If yes, how many? _____

Please identify all facilities/providers you've seen for these conditions, and those you're currently seeing:

Dr. / Provider / Facility	Problem	Type of Treatment Received	When

Medical Information Release (HIPAA Release)

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 contact me via home work cell: _____

If unable to reach me: leave a detailed message leave a message requesting a call back

The best time to reach me is during the day between the hours of ____ and ____.

I authorize Hannouche Family Chiropractic to use my name (first name + last initial only) on our Welcome Board.

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 person listed below:

Spouse _____

Child(ren) _____

Others _____

Release no information without my written verbal consent.

FEMALE PATIENTS: VERIFICATION OF NON-PREGNANCY

I, _____, hereby state that to the best of my knowledge I am not pregnant. It is neither suspected nor confirmed at this time.

Patient Signature: _____

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

MUSCULOSKELETAL

Low Back Pain

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Pain Between Shoulders

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Neck Pain

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Arm Pain

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Joint Pain

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Problems Walking

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Clicking Jaw

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

NERVOUS SYSTEM

Nervous

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Numbness

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Paralysis

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Fainting

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Convulsions

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Cold/Tingling Extremities

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

GASTROINTESTINAL

Excessive Thirst

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Frequent Nausea

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Vomiting

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Diarrhea

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Constipation

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Liver Problems

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Gall Bladder

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Weight Trouble

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Heartburn

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

Colitis

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

GENITO-URINARY

Bladder Trouble

- ___ Mother
- ___ Father
- ___ Children
- ___ Siblings
- ___ Spouse

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C V R (Chest Heart Lungs)

Chest Pain

- Mother
- Father
- Children
- Siblings
- Spouse

Shortness of Breath

- Mother
- Father
- Children
- Siblings
- Spouse

Blood Pressure (Hi/Lo)

- Mother
- Father
- Children
- Siblings
- Spouse

Heart Problems

- Mother
- Father
- Children
- Siblings
- Spouse

Lung Problems

- Mother
- Father
- Children
- Siblings
- Spouse

Ankle Swelling

- Mother
- Father
- Children
- Siblings
- Spouse

Stroke

- Mother
- Father
- Children
- Siblings
- Spouse

MALE / FEMALE

Menstrual Irregularity

- Mother
- Children
- Siblings
- Spouse

Menstrual Cramps

- Mother
- Children
- Siblings
- Spouse

Vaginal

- Mother
- Children
- Siblings
- Spouse

Pain/Infections

- Mother
- Father
- Children
- Siblings
- Spouse

Breast Pain / Lumps

- Mother
- Father
- Children
- Siblings
- Spouse

Prostate/ Sexual Dysfunction

- Mother
- Father
- Children
- Siblings
- Spouse

EENT (Eyes Ears Nose Throat)

Sore Throat

- Mother
- Father
- Children
- Siblings
- Spouse

Earaches

- Mother
- Father
- Children
- Siblings
- Spouse

Hearing

- Mother
- Father
- Children
- Siblings
- Spouse

Heart Problems

- Mother
- Father
- Children
- Siblings
- Spouse

GENERAL

Fatigue

- Mother
- Father
- Children
- Siblings
- Spouse

Allergies

- Mother
- Father
- Children
- Siblings
- Spouse

Headaches

- Mother
- Father
- Children
- Siblings
- Spouse

OTHER SYMPTOMS:

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Thank you for putting your trust in Hannouche Family Chiropractic Clinic. You are in good hands.