

# 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/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? \_\_\_\_\_

How many children do you have? \_\_\_\_ Names and Ages? \_\_\_\_\_

Have they, or any other family members received chiropractic care? Y N If yes, whom? \_\_\_\_\_

Have you ever had chiropractic care? Y N

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**

- Difficulty Urinating
- 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

**MALE**

- Breast Pain / Lumps
- Prostate / Sexual Dysfunction

**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

**FEMALE**

- Menstrual Irregularity or Amenorrhea
- Severe Menstrual Cramps
- Heavy Bleeding
- Breast Pain / Lumps
- Full/Partial Hysterectomy
- Vaginal Pain / Infections

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

**Continued Next Page**

**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.**