HOOGEVEEN CHIROPRACTIC WELLNESS CENTER

GREGG HOOGEVEEN, D.C., C.C.S.P. ADAM HOOGEVEEN, D.C., C.C.W.P.
BROOKE HARRE, D.C. LOGAN HARRE, D.C.

PERSONAL INFORMATION NEEDED TO BETTER SERVE YOU

FIRST NAME: _____ NICKNAME: _____ LAST NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDAY: ____-____-___ SSN: ___-__-____ GENDER: MALE FEMALE MARITAL STATUS: S / M / W / D
HOME PHONE____-____-_____ CELL PHONE_____-_____-_____ WORK PHONE_____-_____-_____

EMPLOYER: _____ OCCUPATION: _____ YEARS AT THIS JOB: _____

SPOUSE'S NAME: _____ KIDS' NAMES (MINORS): _____

EMAIL: _____ WOULD YOU LIKE TO RECEIVE OUR **EMAIL NEWSLETTER**? ☐Y ☐N

REFERRED BY: ☐ PERSON: _____ ☐DOCTOR: _____ ☐GOOGLE ☐OTHER_____

I hereby authorize HOOGEVEEN **CHIROPRACTIC WELLNESS CENTER** to release my records as needed to help in the timely payment of my care. I also authorize third party payers to reimburse Hoogeveen Chiropractic Wellness Center directly. I further agree to pay for all services rendered if my insurance fails to reimburse Dr. Hoogeveen in full, unless otherwise agreed to. This also applies to services that may not be covered by my policy, including if I do not have insurance. I also verify that I am 19 years or older or this is signed by a parent or legal guardian.

NAME PRINTED: X _____
SIGNED: X _____ DATE: ____-____-____

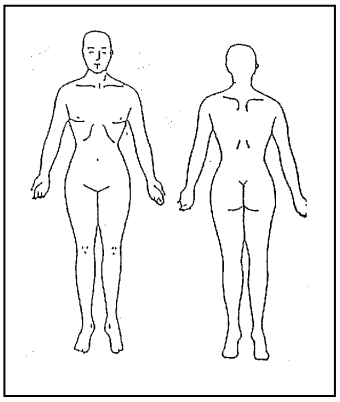
MAIN COMPLAINT:

WHAT IS YOUR MAIN COMPLAINT/SYMPTOM? _____

Symptom Frequency: _____ times per day/week/month (circle one)
Duration of Symptom: CONSTANT OR _____ seconds/minutes/hours (circle one)

IS YOUR PAIN: dull sharp throbbing shooting _____

Mark painful Areas with X's



WHEN DID IT START? _____
HOW DID IT START? _____

WHAT MAKES IT WORSE? _____ **BETTER?** _____

RATE YOUR PAIN (0 = no pain, 10 = the worst pain you can imagine)
(circle) 0 1 2 3 4 5 6 7 8 9 10
FEEL BETTER: (circle) AM PM **FEEL WORSE**: (circle) AM PM

HAVE YOU HAD THIS BEFORE? (circle) YES NO WHEN? _____

OTHER CARE/TREATMENTS FOR THIS CONDITION/SYMPTOM: _____
PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO REASON: _____

GOALS FOR YOUR CARE: ☐ PAIN RELIEF ☐ RESTORING FUNCTION ☐ HEALTHIER SPINE ☐ OVERALL WELLNESS
(CHECK ALL THAT APPLY) ☐ OTHER: _____

OTHER COMMENTS: _____

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COMPLAINT/SYMPTOM NUMBER 2: _____

FREQUENCY: _____ DURATION: _____
DULL SHARP THROBBING SHOOTING _____
WHEN DID IT START? _____ HOW DID IT START? _____
WHAT MAKES IT WORSE? _____ BETTER? _____
RATE YOUR PAIN (0 = no pain, 10 = the worst pain you can imagine) FEEL BETTER: (circle) AM PM
(circle) 0 1 2 3 4 5 6 7 8 9 10 FEEL WORSE: (circle) AM PM
HAVE YOU HAD THIS BEFORE? (circle) YES NO WHEN? _____

COMPLAINT/SYMPTOM NUMBER 3: _____

FREQUENCY: _____ DURATION: _____
DULL SHARP THROBBING SHOOTING _____
WHEN DID IT START? _____ HOW DID IT START? _____
WHAT MAKES IT WORSE? _____ BETTER? _____
RATE YOUR PAIN (0 = no pain, 10 = the worst pain you can imagine) FEEL BETTER: (circle) AM PM
(circle) 0 1 2 3 4 5 6 7 8 9 10 FEEL WORSE: (circle) AM PM
HAVE YOU HAD THIS BEFORE? (circle) YES NO WHEN? _____

MEDICATIONS

_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____
_____

SPINAL INJURIES/SURGERIES

_____
_____

OTHER INJURIES/SURGERIES

_____
_____

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER HEALTH CARE PROVIDER/DOCTOR? ☐ YES ☐ NO
IF YES, FOR WHAT CONDITIONS? _____
NAME OF YOUR MEDICAL DOCTOR: _____ LOCATION: _____
DO YOU GIVE US PERMISSION TO CONTACT YOUR MEDICAL DOCTOR ABOUT YOUR CASE OR OTHER PERTINENT INFORMATION?
☐ YES ☐ NO IF YES, PLEASE SIGN: _____

Review of Systems Are you feeling:

… feverish, excessively fatigued, or had a recent unexpected loss of weight? ❑ YES ❑ NO
… persistent nausea, diarrhea, constipation, chronic abdominal pain, or abnormal stool? ❑ YES ❑ NO
… blurred/double vision, eye pain/discharge, failing vision, or light sensitivity? ❑ Yes ❑ No
… ear pain/discharge, difficulty hearing/swallowing, frequent nose bleeds/sore throat? ❑ Yes ❑ No
… chest pains, fainting spells, irregular heartbeat, shortness of breath, swollen ankles? ❑ Yes ❑ No
… chronic cough, chronic wheezing, coughing up blood, or excessive phlegm? ❑ Yes ❑ No
… painful/bloody/more frequent/uncontrolled urination, unusual genital discharge, genital sores, breast mass/tenderness, excessive menstrual flow/pain, etc? ❑ Yes ❑ No
… weakness, numbness/tingling, seizures/convulsions, tremors/shaking, dizziness? ❑ Yes ❑ No
… skin rashes/itching/chronic dryness, suspicious moles or other patches/markings? ❑ Yes ❑ No
Comments: _____

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LIFESTYLE/WELLNESS INFORMATION

Diet/Nutrition:

Are you on any special diet? ☐ Yes ☐ No If yes, what diet and for what reason? _____

How do you rate your eating habits/diet? (0 = great, 10 = very poor) 0 1 2 3 4 5 6 7 8 9 10

Vitamins/Minerals/Herbs/Supplements

_____

_____

_____

_____

How many 8 oz. glasses of water do you drink per day? _____

How many caffeinated beverages do you drink per day? _____

How many alcoholic beverages? ____ /day ____ /week ____/ month

Do you use tobacco? ☐ Yes ☐ No If yes, what kind? _____

Occupation/Daily Activities/Exercise:

Briefly describe your daily work activities including time spent sitting/standing, computer use, description of any physical labor, repetitive motions: _____

_____

Briefly describe your daily activities at home on most days of the week: _____

_____

I exercise _____ days/week Description of exercise performed: _____

Other Lifestyle/Wellness comments: _____

Our hope is for our patients to understand that lifestyle choices related to diet, exercise, and stress levels can impact your risk for chronic illnesses like heart disease, diabetes, stroke, and even cancer. Would you like your Doctor to discuss your lifestyle/wellness information above in order to enhance overall health and help you reduce your risk for illness and diseas☐ Y☐ Not at this time, but maybe late☐ No, I am only interested in pain relief*

*Please keep in mind that even if you check "Not at this time" or "No…" your Doctor may still discuss some elements of lifestyle in order to assist with the recovery of your current condition/symptoms.

I _____ hereby affirm that all information I have provided on this patient information form is accurate and complete to the best of my knowledge at this time. I have not intentionally falsified or misrepresented any of the information that I provided above, and if any of this information changes in the future I will inform Hoogeveen Chiropractic Wellness Center as soon as possible. I also state that I am 19 years or older and the signature below is either signed by a parent or legal guardian.

Name: _____ Date: _____/_____/_____

Relationship: _____