HOOGEVEEN CHIROPRACTIC WELLNESS CENTER

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

PERSONAL INFORMATION NEEDED TO BETTER SERVE YOU

FIRST NAME: _____ PREFERRED NAME:_____ LAST NAME: _____

ADDRESS: _____ APT#_____ 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: _____

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

MAIN COMPLAINT:

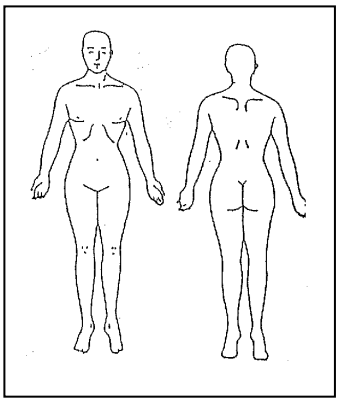
WHAT IS YOUR MAIN COMPLAINT/SYMPTOM? _____

Symptom Frequency: Constant or _____ times per day/week/month (circle one)

Duration of Symptom: _____ 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

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 disease? ☐ Yes ☐ Not at this time, but maybe later* ☐ 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.

Signature: _____ **Date:** ____/____/____

(must be over 19 years of age)

Printed Name _____

"Improving Your Family's Health is Our Family's Mission"

Hoogeveen Chiropractic Wellness Center

Statement of Financial Responsibility

Patient Name: _____ Date of Birth: ____/____/____

Hoogeveen Chiropractic Wellness Center appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage to the best of our ability and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. If other arrangements need to be made, please advise our front desk staff. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim because it is not covered, you could be responsible for that amount.

I have read the above policy regarding my financial responsibility to the Hoogeveen Chiropractic Wellness Center, for providing services to the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Hoogeveen Chiropractic.

Patient Signature: _____ Date: _____

Guarantor/Guardian Signature: _____Date:_____

The person responsible for payments on the above patient's account is:

_____ self

_____ other

Name: _____ Relationship to patient: _____

Address: _____

Phone Number: _____ (in case we have billing questions)

Policy Holder Information (Someone other than myself is the subscriber)

Policy Holder's Name: _____ Date of Birth: _____
Address: _____

_____

_____