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: ________________________ 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:

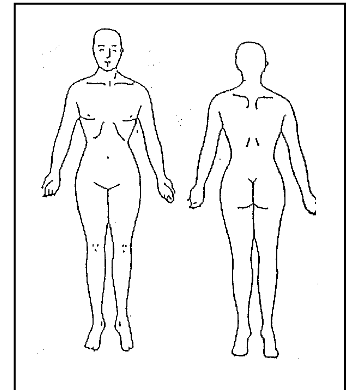
What is your Main Complaint/Symptom? ____

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

Duration of Symptom: _______ seconds/minutes/hours (circle one)

Mark painful Areas with X's

Is Your Pain: 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)
(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.

Patient Name Printed: ____   Date: ____/____/____

Printed Name of Legal Guardian (if patient is a minor-under 19) _______________________________________

Signature: ____ Date: _____/_____/________
(if patient is under 19 years of age, signature must be of legal guardian)

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