HENDRICKSON
CHIROPRACTIC &
WELLNESS CENTER

2020 Jackson St
Oshkosh WI 54901
TEL (920) 236-1200
FAX (920) 236-1201
www.hcochiropractic.com

Confidential Patient Information

Please complete this form as completely as possible and bring it to your first appointment. All information is strictly CONFIDENTIAL. Please print as clearly as possible.

Contact Information

Name:_____ M or F Date:_____/_____/_____

Date of Birth:_____/_____/_____ Age:_____ Status: S M D W O

Current Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____ Soc. Sec. #:_____

Phone(H)_____(W)_____(C)_____

Spouse:_____ # of Children:_____

Occupation:_____ Employer:_____

Spouse Occupation:_____ Spouse Employer:_____

Emergency Contact:_____ Tel:_____

Whom may we thank for referring you?_____

Insurance Information

Is the reason you are here due to an auto accident? YES NO

If yes, have you contacted your auto insurance? YES NO

If yes, do you have a copy of the accident report? YES NO

Is the reason you are here due to an accident you had at work? YES NO

If yes, have you notified your supervisor? YES NO Sup. Name:_____

Has a workers compensation claim been filed? YES NO DON'T KNOW

Are you covered by Medicare? YES NO Medicare ID#:_____

Health History

Reason(s) for seeking chiropractic care and how bad the symptom(s) are:

Primary:_____ Rate (circle) least - 1 2 3 4 5 6 7 8 9 10 - worst

Second:_____ Rate (circle) least - 1 2 3 4 5 6 7 8 9 10 - worst

Third:_____ Rate (circle) least - 1 2 3 4 5 6 7 8 9 10 - worst

Fourth:_____ Rate (circle) least - 1 2 3 4 5 6 7 8 9 10 - worst

Symptoms (circle one): Come & Go Are Constant Vary With Activity

What aggravates your symptoms?_____

What makes your symptoms feel better?_____

Describe any other health problems, including how long you've had them:_____

_____

Are you under the care of any other doctor? YES NO

If yes, what are you being treated for?_____

List any past accidents & dates:_____

List any past surgeries & dates:_____

Have you had x-rays taken within the last 2 years? YES NO

Of what?_____

Date of last physical exam:_____/_____/_____

List any current medications:_____

_____

What vitamins, minerals, or herbs do you take?_____

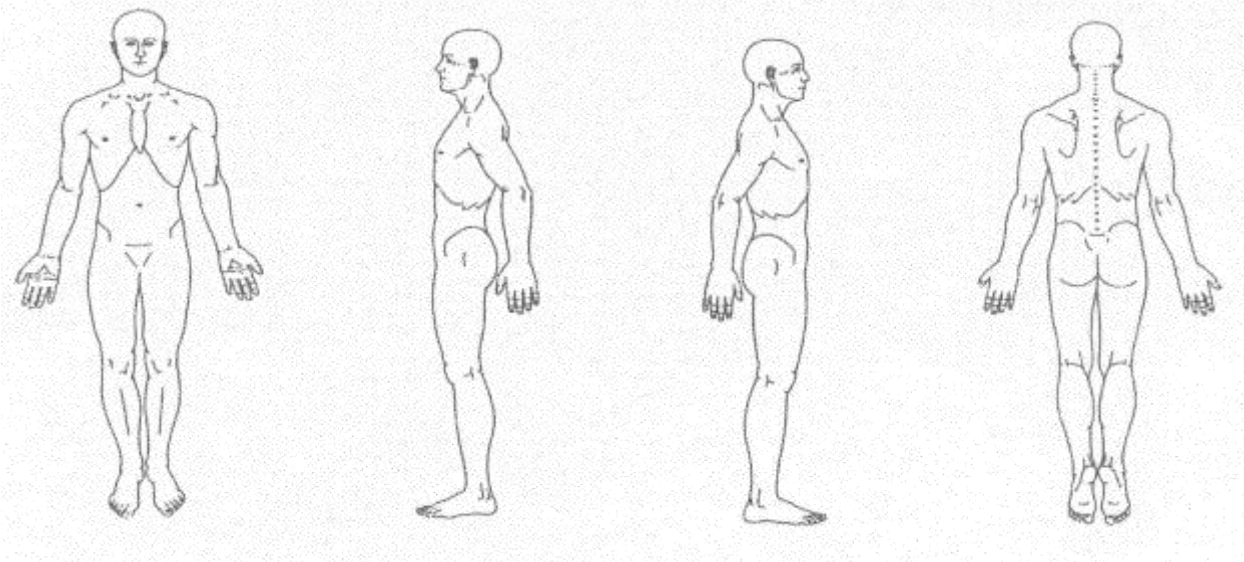
_____

Females only, is there a chance that you might be pregnant? YES NO

Females only, do you exhibit menstrual difficulties? YES NO

Diagram

Please mark on the picture where you have pain or other symptoms. Include symptoms of pain, numbness, tingling, etc.



More Health History

Please check "Past" if you have had any in the past, or "Now" if you have any now:

	Past	Now		Past	Now		Past	Now
ADD/ADHD	☐	☐	Goiter	☐	☐	Pacemaker	☐	☐
AIDS/HIV	☐	☐	Gout	☐	☐	Parkinson's Dis.	☐	☐
Alcoholism	☐	☐	Headaches	☐	☐	Pinched Nerve	☐	☐
Allergies	☐	☐	Heart Disease	☐	☐	PMS	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐	Polio	☐	☐
Anorexia	☐	☐	Hernia	☐	☐	Pain, Neck	☐	☐
Anxiety	☐	☐	Herniated Disk	☐	☐	Pain, Mid-Back	☐	☐
Arthritis	☐	☐	High Cholesterol	☐	☐	Pain, Low Back	☐	☐
Asthma	☐	☐	High Blood Pres.	☐	☐	Prostate Problem	☐	☐
Bleeding Disord.	☐	☐	Irritability	☐	☐	Reflux	☐	☐
Bronchitis	☐	☐	Joint Replacement	☐	☐	Rheumatoid Arth.	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Scoliosis	☐	☐
Chemical Depend.	☐	☐	Liver Disease	☐	☐	Sleep Disorder	☐	☐
Chronic Sickness	☐	☐	Migraine HA	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Miscarriage	☐	☐	STDs	☐	☐
Digestive Trouble	☐	☐	Mononucleosis	☐	☐	Thyroid Probs.	☐	☐
Emphysema	☐	☐	Mood Changes	☐	☐	Tonsillitis	☐	☐
Epilepsy	☐	☐	Multiple Sclerosis	☐	☐	Tumors/Growths	☐	☐
Fractures	☐	☐	Mumps	☐	☐	Urinary Problems	☐	☐
	☐	☐	Osteoporosis	☐	☐	Ulcers	☐	☐

Habits

Please indicate N=None, L=Light, M=Moderate, or H=Heavy for the following:

Alcohol_____ Coffee_____ Tobacco_____

Drugs_____ Exercise_____ Sleep_____

Appetite_____ Soft Drinks_____ Water_____

Salty Foods_____ Sugary Foods_____ Artific. Sweeteners_____

Commitment Level

On a scale of 1 to 10, 10 being the highest, please rate your commitment to getting rid of this problem and improving your health: _____

Concerns that could interfere with your commitment (time, transportation, etc…)

_____

Signature

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge. I agree to allow this office to perform and assessment in order to make as complete evaluation as possible and any appropriate subsequent care.

Patient (or guardian) Signature:_____ Date:_____

Acknowledgment of Privacy Practices

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA policy that is available to you at the front desk before signing this consent form.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care, As an example, the patient agrees to allow this office to submit requested PHI to the health insurance carrier (or other third party payers) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum necessary for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not impact the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the chiropractor has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Printed Name Date

_____

Signature