Hoglen Chiropractic & Laser

PATIENT HEALTH HISTORY FORM

PATIENT INFORMATION

Legal Name: _____ **Called Name:** _____
LAST FIRST MIDDLE (If different than legal name)

Date of Birth: _____ **Sex (legal):** ❑ Male ❑ Female **Pronouns:** ❑ He/Him ❑She/Her ❑ They/Them

Address: _____
STREET CITY STATE ZIP

Primary Phone: _____ ❑ Cell ❑ Home ❑ Work **Secondary Phone:** _____

Email Address: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed **Spouse's Name:** _____

Occupation: _____ **Employer:** _____

Health Insurance Provider: ❑ Blue Cross Blue Shield ❑ Medicare ❑ Other: _____

Do you have a secondary Insurance? ❑ Yes ❑ No **If yes, who is your provider?** _____

How did you find out about our office? ❑ BCBS ❑ Google ❑ Facebook ❑ Referred by _____

CURRENT CONDITION

Primary Complaint: _____ **When did this condition Begin?** _____

Rate the Pain from 1 (least pain) to 10 (severe pain): _____ **Does this occur:** ❑ Daily ❑ Weekly ❑ Monthly

Is the persistence of this pain: ❑ Intermittent (0-25%of the time) ❑ Occasional (25-50% of the time) ❑ Frequent (51-75% of the time) ❑ Constant (76-100% of the time)

Has this condition occurred before? ❑ Yes ❑ No **Please Describe:** _____

List other doctors who have seen you for this condition: _____

Please describe treatments: _____

Is this condition related to: ❑ Work ❑ Auto Accident ❑ Home Injury ❑ Stumble/Fall ❑ Other: _____

Have you filed a claim with any of the following? ❑ Work Comp ❑ Auto Insurance ❑ Employer ❑ Home Ins ❑ None

Date/Time of Accident: _____ **Describe:** _____

Please list all current Medications: _____

_____ **(attach additional sheets if needed)**

Please list all current Supplements: _____

Please list all current Health Conditions: _____

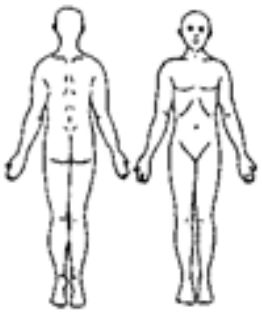
Do you currently:

Use Tobacco	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently
Drink Coffee	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently
Drink Alcohol	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently
Exercise	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently

Daily Activities include: ❑ Lifting ❑ Bending ❑ Standing ❑ Sitting ❑ Pulling ❑ Heavy Labor

Current Height: _____ **Weight**: _____ **Are you Right or Left Handed?** ❑ R ❑ L

Using the diagram to the right, please outline all the area(s) of your current discomfort →



PAST HEALTH STATUS

Previous Chiropractic Care? ❑ Yes ❑ No **If Yes, Previous doctor:** _____ **Last Visit Date:** _____

List any Surgeries/Operations you have had: _____

List any Accidents or Major Falls you have had: _____

List any additional hospitalizations: _____

Please check any of the following diseases you have had EVER IN THE PAST:

	Pneumonia		Anemia		Covid-19		Influenza		Eczema
	Rheumatic Fever		Measles		Diabetes		Pleurisy		HIV
	Polio		Mumps		Cancer		Arthritis		Epilepsy
	Tuberculosis		Chicken Pox		Heart Disease		Rheumatoid Arthritis		
	Whooping Cough		Small Pox		Thyroid Disease		Psoriatic Arthritis		

Please check any of the following diseases you have had IN THE LAST 6 MONTHS:

MUSCULOSKELETAL		**GASTROINTESTINAL**		**CARDIOVASCULAR/RESP**		**EENT**		**NERVOUS SYSTEM**	
	Low Back Pain		Poor Appetite		Chest Pain		Sore Throat		Dizziness
	Upper Back Pain		Excessive Appetite		Shortness of Breath		Ear Aches		Numbness
	Neck Pain		Excessive Thirst		High Blood Pressure		Hearing Difficulty		Palsy / Paralysis
	Arm/Shoulder Pain		Nausea		Low Blood Pressure		Stuffy/Runny Nose		Convulsions/Tremor
	Hip/Leg Pain		Vomiting		Irregular Heartbeat		Sinus Pressure		Fainting
	Joint Stiffness		Diarrhea		Heart Disease		Tonsillar Swelling		Seizures
	Difficulty Walking		Constipation		Lung Problems		Eye Pain	**MENTAL HEALTH**	
	Difficulty Chewing		Hemorrhoids		Chest Congestion		Itching Eyes		Forgetfulness
	Clicking Jaw		Abdominal Cramps		Varicose Veins		Vision Problems		Cold/Tingling Extremities
GENERAL			Liver Problems		Ankle Swelling		Dental Pain/Problems		Stress / Anxiety
	Fatigue		Gall Bladder Problems		Stroke	**GENITO-URINARY**			Depression
	Allergies		Bloating After Meals	**MALE/FEMALE**			Bladder Trouble		Substance Abuse
	Loss of Sleep		Heartburn		Chest/Breast Lumps		Painful Urination		Suicidal Thoughts
	Fever		Black/Bloody Stool		Sexual Dysfunction		Excessive Urination		Nervousness
	Headaches		Colitis		Genital Pain/Infection		Discolored Urine		Confusion

Have any immediate family members been diagnosed with: ❑ Heart Disease ❑ Diabetes ❑ Cancer ❑ Stroke

UTERINE / PREGNANCY HEALTH

Do you have Menstrual Pain/Irregularity? ❑ Yes ❑ No **Please Describe:** _____

Are you Currently Pregnant: ❑ Yes ❑ No **If Yes, Due Date:** _____ **Date of Last Menstrual Period:** _____

Are you Currently Lactating/Breastfeeding: ❑ Y ❑ N **Have you ever experienced postpartum depression?** ❑ Y ❑ N

How many total pregnancies have you had? _____ How many live births? _____ Via: ❑ Vaginal Birth ❑ C-Section ❑ VBAC

Names and ages of children: _____

AUTHORIZATION OF CARE

I authorize payment of insurance benefits directly to Dr. Andrea Hoglen and her office, Hoglen Chiropractic and Laser, PLLC. I authorize this office to release all information necessary to communicate with my health insurance providers, their representatives, and payors in order to secure the payment of my health insurance benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Name (Print): _____ **Patient Signature:** _____ **Date:** _____

If completed by a party other than the patient, name of person who completed the form: _____