

# Hoffman Chiropractic Acupuncture & Sports Rehabilitation

## Confidential Patient Information

Date \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ E-mail \_\_\_\_\_

SSN# \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital: M S W D How many children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's Birth Date \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Is the condition due to injury or sickness arising out of employment? \_\_\_\_\_ # days lost from work \_\_\_\_\_

Is the condition due to injury or sickness arising out of auto or other type of accident? \_\_\_ Date of accident \_\_\_\_\_

Briefly describe the reason for your visit here:

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In the past, have you ever had the same or a similar condition? \_\_\_yes \_\_\_no if yes, please describe: \_\_\_\_\_

Please list all medical or chiropractic physicians you have seen related to your current concern:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

Please describe any special tests (X-ray, MRI, EKG, blood work, etc...) to investigate your current concern.

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Please list any medications you have taken in the past year:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

### LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Hoffman Clinic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing?

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2. If this is a re-occurrence, when did you originally notice the problem? \_\_\_\_\_  
What initially caused it?

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3. Has it changed recently? \_\_\_\_\_ Better \_\_\_\_\_ Worse \_\_\_\_\_ Same What types of treatment have you tried?

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What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

4. How frequent is the condition? \_\_\_\_\_ How long does it last? \_\_\_\_\_

5. Is this affecting your sleep? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe:

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6. Is this affecting your ability to perform your job or daily activities? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe:

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7. Are there any other symptoms that may be related to these concerns, which you have not listed?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Please mark an "X" on the line to indicate the severity of your condition:

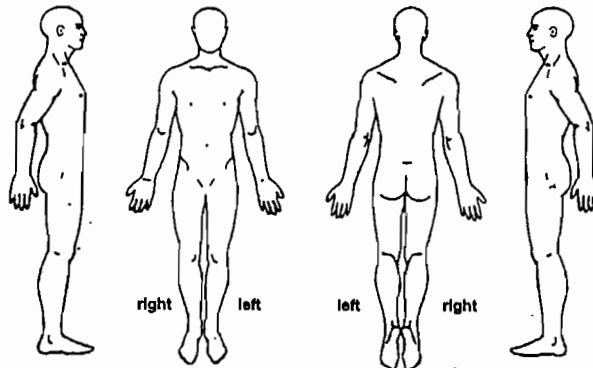
No symptoms  
Does not interfere with activities

Extreme symptoms  
Disabling

1 \_\_\_\_\_ 10

## SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



# Survey of Your Health History

Please circle all that apply. Indicate whether this is a current or old concern by providing an approximate date.

## 1. General

Fever  
Night sweats  
Nervousness  
Bleeding  
Diabetes  
Thyroid  
Headache  
Fainting  
Depression  
Memory loss  
Chills  
Fatigue  
Weight loss/gain  
Anemia  
Cancer  
Substance abuse  
Dizziness  
Seizures  
Phobias  
Waking in night  
Problems falling asleep  
Explain any surgeries or hospitalizations:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any broken bones, car accidents or other injuries?  
\_\_\_\_\_  
\_\_\_\_\_

## 2. Gastrointestinal

Belching/gas  
Vomiting  
Bloody stools  
Hernia  
Constipation  
Diarrhea  
Abdominal pain  
Nausea  
Liver problems  
Other\_\_\_\_\_

## 3. Respiratory

Breathing problems  
Spitting phlegm/blood  
Allergies  
Asthma  
Shortness of breath  
Chronic cough  
Pneumonia  
Other\_\_\_\_\_

## 4. Cardiovascular

Irregular heartbeat  
Racing heart

Chest pain  
High blood pressure  
Swelling  
Prior heart problem  
Pacemaker  
Stroke  
Other\_\_\_\_\_

## 5. Musculoskeletal

stiffness  
Pain  
Swelling  
Spinal curve  
Arthritis  
Weakness  
Twitching  
Tremors  
Numbness  
Other\_\_\_\_\_

## 6. Skin

Rashes  
Mole changes  
Itching  
Nail changes  
Redness  
Other\_\_\_\_\_

## 7. EENT

Blurry vision  
Double vision  
Eye pain  
Jaw pain  
Hearing loss  
Ringing in ears  
Ear infection  
Sinus problems  
Nosebleeds  
Throat problems  
Speech problems  
Glasses or contact?\_\_\_\_\_

## 8. Genitourinary

Frequent/painful urination  
Incontinence  
Blood in urine or stool  
Urinary infection  
Venereal infection  
Other\_\_\_\_\_

## 9. Women Only

Difficult periods  
Hot flashes  
Irregular cycles  
Breast pain  
Lump in breast

Difficulty becoming pregnant  
Complications of pregnancy  
Other\_\_\_\_\_

Date last period ended\_\_\_\_\_

Date last gyne exam\_\_\_\_\_

## 10. Men Only

Testicular pain  
Prostate problems  
Difficult erection  
Low sperm count

## 11. Exercise

None  
1-2 per week  
3-4 per week  
5-7 per week  
What type?\_\_\_\_\_

## 12. Habits

Smoke(\_\_\_\_packs/day, years?\_\_\_\_)  
Alcohol(\_\_\_\_drinks per wk)  
Caffeine(\_\_\_\_cups per day)  
Recreational drug use\_\_\_\_\_

## 13. Family

Are your parents living?\_\_\_\_\_  
If so, do you consider them to be in good health?\_\_\_\_\_  
Ages:Mother\_\_\_\_\_ Father\_\_\_\_\_

Circle any below that apply to your parents, siblings or children:

Diabetes  
Stroke  
Hypertension  
Cancer  
Seizures  
Tremors  
Brain disorder  
Heart disease  
Lung disease  
Arthritis  
Scoliosis