WELCOME TO HAUSER CHIROPRACTIC AND ACUPUNCTURE

PATIENT INFORMATION

Patient Name_____ Date_____
(Last) (First) (M.I.)
SSN_____-_____-_____ Address_____

City_____ State_____ Zip_____ E-mail_____

Home Phone (___)_____ Cell Phone (___)_____ Age____ Birth date_____

Sex ☐ Male ☐ Female ☐ Married ☐Widowed ☐Single ☐Separated ☐Divorced

Do you have children? ☐ Yes ☐ No Age(s)?_____ Do they play sports? ☐ Yes ☐ No

Occupation_____ Employer/School_____

Who referred you to us?_____

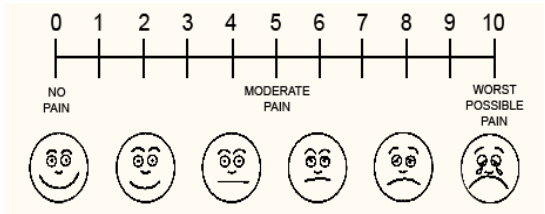
Family Medical Doctor:_____

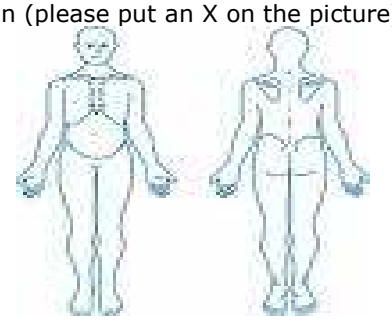
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Emergency Contact_____ Relation_____ Phone(__)_____

REASON FOR VISIT

What brought you in today?_____
When did you first notice your symptoms?_____
How often does your pain occur?_____ Does it come or go?_____
Have your symptoms gradually gotten worse? ☐ Yes ☐ No ☐Unknown
Severity of pain (please circle): Location of pain (please put an X on the picture)





Type of Pain:

☐Sharp	☐Burning	☐Dull	☐Tingling	☐Cramps	☐Numbness
☐Stiffness	☐Aching	☐Swelling	☐Shooting	☐Throbbing	☐Other

Does your pain interfere with ☐Work ☐Sleep ☐Daily Life ☐Recreation

Are any of these activities painful ☐Sitting ☐Standing ☐Walking ☐Bending over ☐Lying Down

Is your condition due to an accident? ☐Yes_____ ☐No
Date

If yes, Type of Accident ☐Auto ☐Work ☐Home ☐Other
To who have you reported the accident? ☐Auto Insur. ☐Employer ☐Workers Comp.
Name of Attorney (if applicable)_____

HEALTH HISTORY

What treatment have you received for this condition? ☐Medication ☐Surgery ☐Physical Therapy ☐Chiropractic ☐Acupuncture ☐None ☐Other

Name of providers who have treated your condition_____

Date of Last: Physical Exam_____ Spinal Exam_____ Spinal X-Ray_____
Chest X-Ray_____ MRI, CT-Scan, Bone Scan_____

Are you pregnant ☐Yes ☐No If yes, Due Date_____

Please check if you currently experience or have experienced any of the following:

AIDS-HIV	☐	Diabetes	☐	Measles	☐		
Alcoholism	☐	Emphysema	☐	Migraine Headaches	☐	Rheumatoid	☐
Allergy Shots	☐	Epilepsy	☐			Rheumatic Fever	☐
Anemia	☐	Fractures	☐	Miscarriage	☐		
Anorexia	☐	Glaucoma	☐	Mononucleosis	☐	Scarlet Fever	☐
Appendicitis	☐	Goiter	☐	Multiple Sclerosis	☐	STD	☐
Arthritis	☐	Gout	☐			Stroke	☐
Asthma	☐	Heart Disease	☐	Mumps	☐	Suicide Attempt	☐
Bleeding Disorders	☐	Hepatitis	☐	Osteoporosis	☐		
		Hernia	☐	Pacemaker	☐	Thyroid	☐
Breast Lump	☐	Herniated Disk	☐	Parkinson's Disease	☐	Tonsillitis	☐
Bronchitis	☐					Tuberculosis	☐
Bulimia	☐	Herpes	☐	Pinched Nerve	☐	Tumors	☐
Cancer	☐	High Blood Pressure	☐	Pneumonia	☐	Typhoid Fever	☐
				Polio	☐		
Cataracts	☐					Ulcers	☐
Chemical Dependency	☐	Cholesterol Problems	☐	Prostate Problem	☐	Vaginal Infections	☐
Chicken Pox	☐	Kidney Disease	☐	Prosthesis	☐	Whooping Cough	☐
				Psych Care	☐		

EXERCISE		**WORK ACTIVITY**		**HABITS**		**HABITS CONT.**
None	☐	Sitting	☐	Smoking	☐	Packs/day_____
Moderate	☐	Standing	☐	Alcohol	☐	Drinks/wk_____
Daily	☐	Light Labor	☐	Caffeine	☐	Cups/day_____
Heavy	☐	Heavy Labor	☐	High Stress	☐	Reason_____

MEDICATION	**ALLERGIES**	**VITAMINS**	**INJURIES**	
_____	_____	_____	Falls	☐
_____	_____	_____	Head Injuries	☐
_____	_____	_____	Broken Bones	☐
_____	_____	_____	Dislocations	☐
_____	_____	_____	Surgeries	☐

INSURANCE

Who is responsible for this account?_____ Relationship to Patient_____
Insurance Company_____ Member ID_____
Is patient covered by additional insurance? ☐ Yes ☐No

If yes, Subscribers Name_____ Date of Birth_____ SS#_____

Insurance Co._____ Group Number_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. Lance Hauser all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Name of Patient, Parent, Guardian or Personal Representative (Print) Signature Date

_____
Relationship to Patient