Patient # _________

Hogue Chiropractic Center

First Name:_____________________ Middle Initial:_____ Last Name:______________________

Do you prefer to go by another name or nickname?_____________________________________

Home Address:__________________________ City:________________ State:_______ Zip:______

Date of Birth:_________________________ Age:____________ Social Security #:______________

Please Circle: Male / Female Please Circle: Single / Married / Widowed / Divorced

Home #:_______________________ Cell #:_________________________ Work #:____________

Emergency Contact Name:_________________________ Emergency Contact #:_______________

Email Address:__________________________________ Who referred you to us?______________

Employer:____________________________________ Occupation:__________________________

Physician's Name and Address:____

HEALTH INSURANCE INFORMATION:

****PLEASE BE ADVISED THAT WE ARE OUT OF NETWORK WITH ALL MEDICAID, CIGNA, AND AETNA PLANS****

Insurance Company:______________________ Are you covered as Self, Spouse or Child?______

Subscriber's Name:_______________________ Subscriber's Date of Birth:__________________

Insurance ID #:________________________________ Insurance Group #:____________________

FINANCIAL AGREEMENT

I authorize the use of this information for insurance billing. I authorize the release of information to the insurance company. I understand that I am responsible for my charges for services. I authorize payment to Hogue Chiropractic Center. I permit a copy of this authorization to be used in place of the original.

Sign:____ Date:_________________________

Name: ______________________________ **Date:** ______________

Please list your chief complaints: ______________________________

____

Please circle what best describes your symptoms: **Mild / Moderate / Severe**

What worsens your symptoms? ______________________________

What makes your symptoms better? ______________________________

How long have your symptoms been present? ______________________________

Please circle how your symptoms started: **Suddenly / Gradually / Long-standing problem**

Please circle what best describes your symptoms: **Constant / Progressive / Intermittent**

Have you had the same or similar symptoms in the past? ______________________________

Have you had prior treatment or testing for this problem? ______________________________

Are your symptoms due to a recent injury? ______________ **Date of injury:** ______________

If so, please circle type of injury: **Auto Accident / Personal Injury / Workers Compensation**

Please describe your accident or injury: ______________________________

Have you had any past injuries? ______________________________

Please list the year and type of injury: ______________________________

Do your symptoms interfere with: **Daily living? Y / N** **Sleep? Y / N** **Lifestyle? Y / N** **Work? Y / N**

Have you missed work due to this problem: ______________________________

Please list all of your current medications: ______________________________

____

Please list all surgeries you've ever had (including breast implants): ______________________________

____

Have you had any significant past illnesses? ______________________________

Do you have any family history of illness (Ex. Diabetes, High Blood Pressure)? ______________

____

Father's Age: ___________ Living / Deceased Cause of Death: ____

Mother's Age: ___________ Living / Deceased Cause of Death: ____

Please describe your Alcohol usage: ____

Please describe your Tobacco usage: ____

Do you exercise? ___________________________ Types of exercise: ____

Number of children? _________ Women: Is there any chance you are currently pregnant? _____________

Please circle the conditions that best describe your work environment:

Loud / Lung Pollutant / Extreme Hot/Cold / Constant Sitting / Constant Standing / Lifting

Heavy Data Entry / Stressful / No Problems

Have you experienced any recent traumas (Ex. Divorce, Death of Family/Friend, Loss of Job)? __________

____

Have you been treated by a chiropractor before? ___________ Name of chiropractor: ____________________

Were your results satisfactory? ____

Please circle each condition you have recently experienced:

Fatigue Joint Pain Headaches Stiff Neck Inflammation Numbness Scoliosis

Muscle Ache Muscle Cramps Muscle Spasm Muscle Weakness Tenderness Stiffness

Arthritis Abnormal Posture Fracture/Dislocation Bladder Infection Diarrhea Constipation

Recent Trauma Sprain Menstrual Problems Numbness in Legs Nervousness Irritability

Sleep Disorder Short of Breath High Blood Pressure Depression Tension Loss of Memory

Loss of Balance Loss of Taste/Smell

Have you been diagnosed with HIV/Aids or Hepatitis? ____

If yes, please tell us which type of hepatitis and year of diagnosis: ______________________________________

Pain Chart

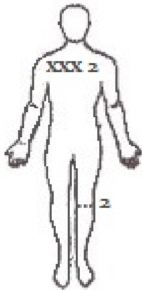
Please rate the severity of pain you have generally felt over the past few days by circling one box on the pain scale below.

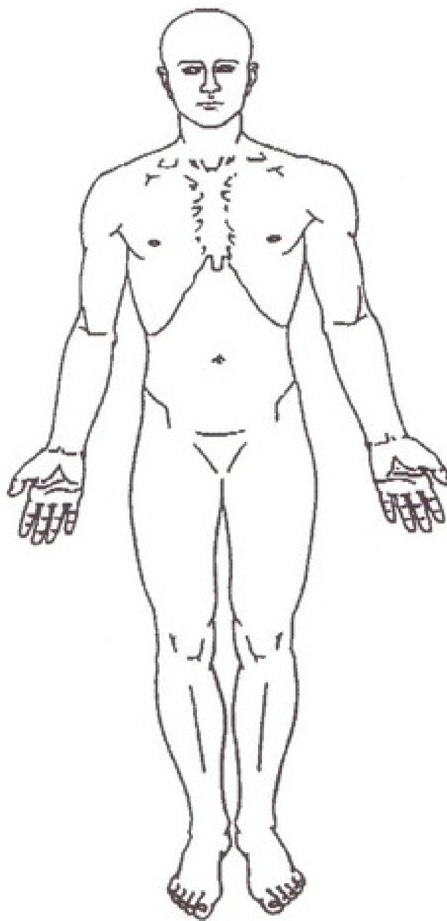
(0 = No pain 10 = Excruciating pain)

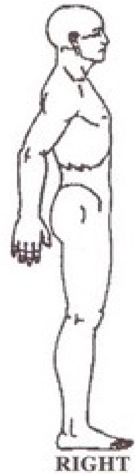
0	1	2	3	4	5	6	7	8	9	10

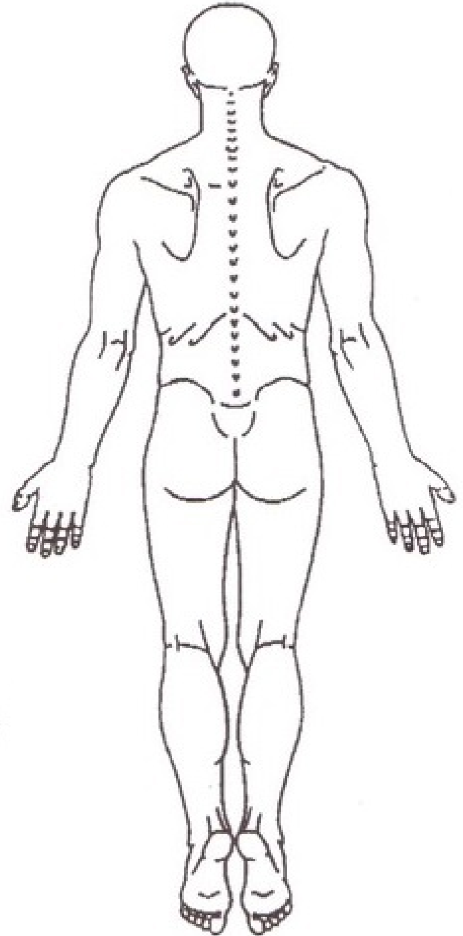
Please mark areas of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) through 10 (extreme pain).

Pain = PPP Numbness = --- Pins & Needles = ooo Burning = ^^^ Aching = xxx Stabbing = ...









I have read the information in this packet and I have anwered to the best of my ability.

Sign: ______________________________ **Date:** ____________________