Hennicken Family Chiropractic

Member ID # _____ (for office use only) Date: ___/___/___

Your Information:

Name (Mr., Mrs., Ms., Dr.) _____ H. Phone _____

Home Address: _____ C. Phone _____

City: _____ State: _____ Zip Code _____

SS#: _____ Email: _____

Age: _____ Date of Birth: ___/___/___ Single / Married / Widowed / Divorced / Other: _____

Occupation: _____ Employer: _____

Address, City, State: _____ W. Phone _____

Your Family:

Spouse's Name _____ SS#: _____ # of Children: _____ Age's: _____

Spouse's Employer: _____ Spouse's Date of Birth: ___/___/___

Health Care Information:

Previous Chiropractic Care: YES NO Doctor: _____ Last Visit: ___/___/___

Current Medical Doctor: _____ Last Visit: ___/___/___

Health Insurance:

Insured on Policy: _____

Name of Health Ins Company: _____

(We will need to make copies of your Insurance Card(s) and Driver's License)

Reason for seeking care:

_____ ___/___/___

Major Complaint or Concern Onset of condition

_____ _____ _____

In case of emergency contact Relationship Phone Number

How did you hear about us? ↓ Or did someone refer you here Their name _____

Live Nearby / Activator.com / Yellow Book / Talking Phone Book / Yellow Pages / Website / Online Phone Book / Health Fair

It is usual and customary to pay for services as rendered unless otherwise arranged

I do hereby authorize Dr. Paul J. Hennicken to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis and etc. of myself in regards to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him or her for chiropractic service rendered to me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him or her for service rendered to me. This agreement is made solely for the said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he or she will not await payment but may declare the entire balance due and payable/these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient Signature: _____ Date: ___/___/___

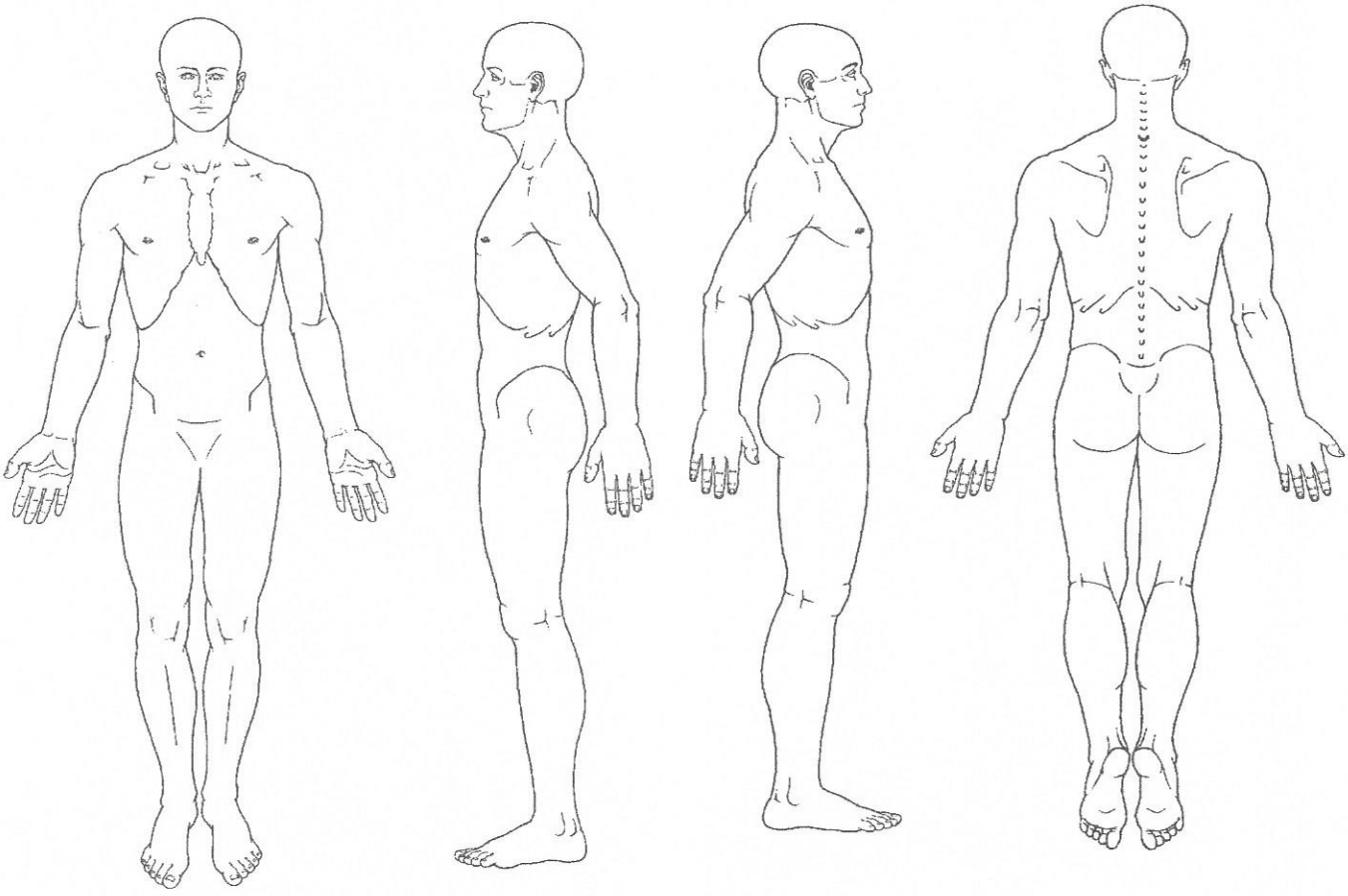
Over Please ➡

Intial Eval: _____
Re- Eval: _____

PAIN LOCATION

Patient Name:_____ File #:_____ Date:_____

Right **Front** *Left* Left Side Right Side *Left* **Back** *Right*



Please mark off the areas of your complaint on the diagram above. Use the symbols below on the pain diagram to accurately describe your condition. Then, place a rating on a scale of 1 – 10, 1 being minimal and 10 being the worst next to symbol indicating your complaint(s).

ex, P4, M7, etc.

P **Where you experience Pain**
N **Where you experience Numbness**
T **Where you experience Tingling**
B **Where you experience Burning**
C **Where you experience Cramping**
M **Where you experience Muscle Tension**

3575 Rutherford Rd. Extension Ste C • Taylors, SC 29687
Ph: 864-292-1961 • Cell Ph: 864-363-5239 • Fax: 864-292-1961

Hennicken Family Chiropractic

"Reconnecting Brain to Body"

Dr. Paul J. Hennicken

Our Purpose:

Here at Hennicken Family Chiropractic, we like to clarify what it is we do and do not so in our office. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra that make up the spinal column, which causes changes to the nervous system function and interferes with the transmission of mental inpulses, Lessening the body's ability to express its maximum health potential. Health is defined as a state of optimal physical, mental and social well-being, not merely the absense of disease or infirmity or symptoms. We apply a specific application of force to the involved segment(s) to allow the body to correct these vertebral subluxations. We do not make a direct or indirect guarantee that these adjustments will have a direct effect on any condition with which a person may be presenting.

However, If during the course of a chiropractic spinal evaluation, we encounter a non-chiropractic or unusual findings we will advise you to seek medical attention from someone who specializes in those types of issues.

Consent to Chiropractic Care:

I have had an opportunity to discuss with the doctor of chiropractic named above, and / or with any other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, muscular discomfort, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate or explain all of the risks and complications, and I wish to rely on the doctor to exercise their best judgement during the course of the procedure, based on facts known at that time, and as in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me by the doctor of chiropractic named above. I also request and give my consent for other licensed doctors of chiropractic who now or in the future may treat me while employed or associated with this office that may serve as a back up doctor for the doctor named above, including those working at this office or another office or clinic.

I have read, or have been read the above consent. I have also had an opportunity to ask questions about its consent, and by initialing below and signing the privacy and consent form I agree to the above named procedures. I choose to have my subluxations adjusted. I understand that the adjustments in this office are not treatment of any condition, symptom or ailment. I also understand that Hennicken Family Chiropractic is not discouraging my seeking the service of any other type of practicioner. I intend this consent form to cover the entire course of care that I receive presently and in the future.

Patient's Initials	Doctor's Initials	/ / Date

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PRIVACY NOTICE ACKNOWLEDGEMENT

We at Hennicken Family Chiropractic are very concerned with protecting your privacy especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996* (HIPAA), we are required to supply you with a copy of our privacy policies and procedure. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, We would be happy to address them.

By signing below I acknowledge that I have received a copy of Hennicken Family Chiropractic's *Privacy Policy* and agree to its terms. I have also read your consent policy and agree to its terms.

_____ _____ / / _____

Patient Name (Please Print) Date:

_____

Patient or Legal Guardian's Signature

INFORMATION AND PHOTO RELEASE CONSENT

We like to celebrate all new arrivals with the rest of our chiropractic family by sharing a photo of you with your name, city and state in which you reside. Information would be posted on our New Additions board, newsletters and/or patient of the month achievements.

If you agree to allow us to use your photo please mark yes and place your intial next to it. If you choice not to allow us to use your information there will be no repercussions for your decision; we understand and respect your privacy. If that is the case, please mark no and place your initials next to it.

☐ YES _____ Initials ☐ NO _____ Initials

MESSAGE CONTACT INFORMATION

I understand that this office may call me to leave a message concerning some aspect of my care. I authorize them to leave a message at the following number(s).

_____ Primary Number _____ Secondary Number ☐ _____ Initials

_____ / / _____

Doctor's Signature Date:

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CASE HISTORY

Thank you for completing this detailed health history. Please circle each individual answer and provide additional information when indicated. Include both ***past*** and ***present*** conditions. If you are not sure what a question means, leave it blank and your doctor will review it with you later.

Family History			
001	Y	N	Diabetes
002	Y	N	Thyroid disease-
003	Y	N	Kidney disease-
004	Y	N	High blood pressure
005	Y	N	Heart disease-
006	Y	N	Musculoskeletal disease
007	Y	N	Cancer-
008	Y	N	Stroke
009	Y	N	Other family history

Patient's Current General History			
010	Y	N	Recent weight change, ↑ ↓
011	Y	N	Periodic unexplained sweats
012	Y	N	Reoccurring Allergies
013	Y	N	Anemia
014	Y	N	Malaise / fatigue / weakness
015	Y	N	HIV positive
016	Y	N	Cancer-
017	Y	N	Thyroid conditions:
018	Y	N	Diabetes
019	Y	N	Neck surgery / irradiation
020	Y	N	Other:

Reproductive System			
021	Y	N	Genital lesions
022	Y	N	Genital mass / growths / pain
023	Y	N	Other:

Neurological System			
024	Y	N	Headaches, How often? _____
025	Y	N	Seizures / Epilepsy
026	Y	N	Tics / twitches / spasms
027	Y	N	Dizziness
028	Y	N	Numbness or tingling
029	Y	N	Unusual weakness
030	Y	N	Head Trauma
031	Y	N	Stroke
032	Y	N	Disk herniation
033	Y	N	Other-

Cardiovascular System			
034	Y	N	Shortness of breath From exercise? Y N
035	Y	N	Chest discomfort / pain
036	Y	N	Palpitations
037	Y	N	Edema
038	Y	N	Fainting
039	Y	N	Sudden calf pain while walking
040	Y	N	High BP – Medication Y N
041	Y	N	Past heart disease
042	Y	N	Rheumatic fever

Hospitalizations / Medications			
043	Y	N	Have you ever been hospitalized or had surgery?
044	Y	N	Current medications or drugs Medication

Eye / Ear / Nose / Throat			
045	Y	N	Corrective Lenses
046	Y	N	Eye Pain
047	Y	N	Other Visual Conditions:
048	Y	N	Glaucoma
049	Y	N	Difficulty hearing / deafness
050	Y	N	Ringing in ears / dizziness
051	Y	N	Ear pain
052	Y	N	Change in ability to smell
053	Y	N	Sinus pain or congestion
054	Y	N	Hoarseness
055	Y	N	Change in voice
056	Y	N	Difficulty chewing / swallowing
057	Y	N	Enlarged / painful glands
058	Y	N	Other:

Breasts (Male and Female)			
059	Y	N	Breast lumps / mass / growths / pain / tenderness
060	Y	N	Dimples in breast
061	Y	N	Change in color / size / shape
062	Y	N	Nipple discharge / bleeding
063	Y	N	Other:

Pulmonary System			
064	Y	N	Difficulty breathing
065	Y	N	Cough
066	Y	N	TB exposure / test / X-Ray
067	Y	N	Cigarettes: past / present
068	Y	N	Other tobacco: past /present
069	Y	N	Other:

Skin / Hair / Nails			
070	Y	N	Change in skin texture
071	Y	N	Change in skin temperature
072	Y	N	Skin dryness or perspiration
073	Y	N	Unusual skin coloration
074	Y	N	Rashes / itching / lesions
075	Y	N	Skin growths
076	Y	N	Mole changes
077	Y	N	Skin Cancer-
078	Y	N	Skin Pain-
079	Y	N	Other:

Psychological History			
080	Y	N	Anxiety
081	Y	N	Depression
082	Y	N	Hospitalization for psychological care
083	Y	N	ADHD or Bipolar
084	Y	N	Other:

Implants / Orthopedic Supports			
085	Y	N	Breast implants
086	Y	N	Cardiac (pacemaker, etc.)
087	Y	N	Joint Implants-
088	Y	N	Other Implants / Supports (including heel or sole lifts) Type?
089	Y	N	Pins / Plates / Staples?

Gastrointestinal System			
090	Y	N	Change in appetite
091	Y	N	Food intolerance
092	Y	N	Nausea / vomiting
093	Y	N	Vomiting of blood
094	Y	N	Peptic ulcer
095	Y	N	Indigestion / Heartburn
096	Y	N	Abdominal pain (stomach)
097	Y	N	Abdominal swelling
098	Y	N	Abnormal flatulence (gas)
099	Y	N	Change in bowel habits or stool (color, consistency etc.)
100	Y	N	Diarrhea / Constipation
101	Y	N	Gallbladder disease
102	Y	N	Liver disease
103	Y	N	Pancreas disorder
104	Y	N	Alcohol intake
105	Y	N	Other:

Urinary System			
106	Y	N	Frequent urination
107	Y	N	Increased thirst?
108	Y	N	Change in urine
109	Y	N	Hesitancy
110	Y	N	Urethral discharge
111	Y	N	Urinary tract infections
112	Y	N	Kidney disease / Stones
113	Y	N	Mid back/flank (side) pain

Musculoskeletal System			
114	Y	N	Joint stiffness/change in motion
115	Y	N	Joint pain
116	Y	N	Joint swelling
117	Y	N	Muscle cramps
118	Y	N	Muscle weakness
119	Y	N	Muscle wasting
120	Y	N	Neck pain
121	Y	N	Upper / mid back pain
122	Y	N	Low back pain
123	Y	N	Buttock pain
124	Y	N	Shoulder / arm / hand condition: Left Right
125	Y	N	Leg / knee / ankle / foot condition : Left Right
126	Y	N	Fractures / dislocation / sprains: Location:
127	Y	N	Other injuries – include auto accidents
128	Y	N	Other:

Other	
129	Is there anything else we need to know about you?

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

Patient Intials _____ Date _____