WELCOME

PATIENT INFORMATION

DATE: _____
SS/ID#_____
PATIENT NAME_____
LAST NAME

_____ _____
FIRST NAME MIDDLE INITIAL

ADDRESS_____
CITY_____
STATE_____ ZIP_____
EMAIL_____@_____

SEX ☐ M ☐F AGE_____
BIRTHDAY_____

☐MARRIED ☐WIDOWED ☐SINGLE ☐MINOR

☐SEPARATED ☐DIVORCED ☐PARTNERED FOR___YEARS

OCCUPATION _____
PATIENT EMPLOYER/SCHOOL _____
EMPLOYER/SCHOOL ADDRESS _____
_____
EMPLOYER/SCHOOL PHONE _(____)_____-_____
SPOUSE'S NAME _____
BIRTHDAY_____
SS#_____
SPOUSE EMPLOYER _____
WHOM MAY WE THANK REFERRING YOU? _____

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?
_____
RELATIONSHIP TO PATIENT _____
INSURANCE CO. _____
GROUP #_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐Y☐N
SUBSCRIBER'S NAME _____
BIRTHDATE_____SS#_____
RELATIONSHIP TO PATIENT _____
INSURANCE CO. _____
GROUP # _____

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH
_____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **DR. ZANE HOFFMAN** 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 FOR 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 PAYMENTS 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.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____ _____
DATE RELATIONSHIP TO PATIENT

PHONE NUMBERS

HOME PHONE (_____)_____
CELL PHONE (_____)_____
BEST TIME AND PLACE TO REACH YOU
_____
IN CASE OF EMERGENCY, CONTACT

NAME _____
RELATIONSHIP _____
HOME # (_____)_____
WORK # (_____)_____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
DATE_____

TYPE OF ACCIDENT ☐AUTO ☐WORK ☐HOME ☐ OTHER

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?

☐AUTO INSURANCE ☐EMPLOYER ☐WORKERS COMPENSATION ☐ OTHER

ATTORNEY NAME (IF APPLICABLE)
_____

PATIENT CONDITION

REASON FOR VISIT _____ HEIGHT _____ WEIGHT_____

WHEN DID YOUR SYMPTOMS APPEAR? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? ☐YES ☐NO ☐ UNKNOWN

MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1(LEAST PAIN) TO 10 (SEVERE PAIN). ____

TYPE OF PAIN: ☐ SHARP ☐DULL ☐ THROBBING ☐ NUMBNESS ☐ACHING ☐ SHOOTING
☐BURNING ☐ TINGLING ☐ CRAMPS ☐STIFFNESS ☐ SWELLING ☐ OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? _____

IS IT CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH YOUR ☐ WORK ☐SLEEP ☐ DAILY ROUTINE ☐RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM ☐SITTING ☐STANDING ☐ WALKING ☐ BENDING ☐LYING DOWN

HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOU CONDITION?

MEDICATIONS SURGERY PHYSICAL THERAPY CHIROPRACTIC SERVICES NONE
OTHER _____

NAME AND ADDRESS OF OTHER DOCTORS WHO HAVE TREATED YOUR CONDITION _____

DATE OF LAST: PHYSICAL EXAM _____ SPINAL X-RAY _____ BLOOD TEST _____
SPINAL EXAM _____ CHEST X-RAY _____ URINE TEST _____
DENTAL X-RAY _____ MRI, CT-SCAN, BONE SCAN _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ONE OF THE FOLLOWING:

AIDS/HIV ☐YES ☐ NO	DIABETES ☐YES ☐ NO	MIGRAINE-HEADACHES ☐YES ☐ NO	STROKE ☐YES ☐ NO
ALCOHOLISM ☐YES ☐ NO	EMPHYSEMA ☐YES ☐ NO	MISCARRIAGE ☐YES ☐ NO	SUICIDE ATTEMPT ☐YES ☐ NO
ALLERGIES SHOT ☐YES ☐ NO	EPILEPSY ☐YES ☐ NO	MONONUCLEOSIS ☐YES ☐ NO	THYROID PROBLEMS☐YES☐ NO
ANEMIA ☐YES ☐ NO	FRACTURES ☐YES ☐ NO	MULTIPLE SCLEROSIS ☐YES ☐ NO	TONSILLITIS ☐YES☐ NO
ANOREXIA ☐YES ☐ NO	GLAUCOMA ☐YES ☐ NO	MUMPS ☐YES ☐ NO	TUBERCULOSIS ☐YES ☐ NO
APPENDICITIS ☐YES ☐ NO	GOITER ☐YES ☐ NO	OSTEOPOROSIS ☐YES ☐ NO	TUMORS GROWTH ☐YES ☐ NO
ARTHRITIS ☐YES ☐ NO	GONORRHEA ☐YES ☐ NO	PACEMAKER ☐YES ☐ NO	THYROID FEVER ☐YES ☐ NO
ASTHMA ☐YES ☐ NO	GOUT ☐YES ☐ NO	PARKINSON'S DISEASE ☐YES ☐ NO	ULCERS ☐YES ☐ NO
BLEEDING DISORDERS ☐YES ☐ NO	HEART DISEASE ☐YES ☐ NO	PINCHED NERVE ☐YES ☐ NO	VAGINAL INFECTIONS ☐YES ☐NO
BREAST LUMP ☐YES ☐ NO	HEPATITIS ☐YES ☐ NO	PNEUMONIA ☐YES ☐ NO	VENEREAL DISEASE ☐YES ☐NO
BRONCHITIS ☐YES ☐ NO	HERNIA ☐YES ☐ NO	POLIO ☐YES ☐ NO	WHOOPING COUGH ☐YES☐ NO
BULIMIA ☐YES ☐ NO	HERNIATED DISK ☐YES ☐ NO	PROSTATE PROBLEM ☐YES ☐ NO	OTHER _____
CANCER ☐YES ☐ NO	HERPES ☐YES ☐ NO	PROSTHESIS ☐YES ☐ NO	
CATARACTS ☐YES ☐ NO	HIGH CHOLESTEROL ☐YES ☐ NO	PSYCHIATRIC CARE ☐YES ☐ NO	
CHEMICAL ☐YES ☐ NO	KIDNEY DISEASE ☐YES ☐ NO	RHEUMATOID ARTHRITIS ☐YES ☐ NO	
DEPENDENCY ☐YES ☐ NO	LIVER DISEASE ☐YES ☐ NO	RHEUMATIC FEVER ☐YES ☐ NO	
CHICKEN POX ☐YES ☐ NO	MEASLES ☐YES ☐ NO	SCARLET FEVER ☐YES☐ NO	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ NONE	☐ SITTING	☐ SMOKING	PACKS A DAY _____
☐MODERATE	☐ STANDING	☐ALCOHOL	DRINKS/WEEK_____
☐DAILY	☐ LIGHT LABOR	☐COFFEE/CAFFEINE DRINKS	CUPS/DAY _____
☐HEAVY	☐ HEAVY LABOR	☐HIGH STRESS LEVEL	REASON _____

ARE YOU PREGNANT? ☐YES ☐ NO DUE DATE_____

INJURIES/SURGERIES YOU HAVE HAD

	DESCRIPTION	**DATE**
FALLS	_____	_____
HEAD INJURIES	_____	_____
BROKEN BONES	_____	_____
DISLOCATIONS	_____	_____
SURGERIES	_____	_____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
_____	_____	_____
_____	_____	_____
PHARMACY NAME _____	_____	_____
PHARMACY TEL# _____		