HUDSON CHIROPRACTIC

Name _____ Age _____ DOB _____/_____/_____

Email _____ SS# _____-_____-_____

Address _____ City _____ State _____ Zip _____

Marital Status: S M D W # of Children _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Spouse or Guardian _____ DOB _____/_____/_____

Spouse SS# _____-_____-_____ Spouse Employment _____

Where are you Employed? _____ Address _____

Occupation _____ How did you hear about us? _____

Have you had previous Chiropractic care? Yes / No If yes, how long ago? _____

List any surgeries (and dates) you have had _____

_____

Family History (Such as cancer, Diabetes, High Blood Pressure, etc.) _____

_____

List **ALL** medications and supplements you are currently taking _____

_____

TO THE PATIENT: Please list below your chief complaints in order of their importance.

_____ How long? _____

_____ How long? _____

_____ How long? _____ Is this condition related to an accident? Yes / No Date of Acciden _____

Is this condition related to Employment? Yes / No Auto Accident? Yes / No

Other, explain _____

Have you sought medical treatment for this/these problems? Yes / No

Name of Doctor seen _____ Primary Care Physician _____

Are you here for: Relief of symptoms? Yes / No Correction of Problem? Yes / No

Follow-up care after correction? Yes / No

INSURANCE INFORMATION

Name of Insurance Company _____

Name of policy Holder _____ Relationship to Patient _____

ID # _____ Group # _____

AUTHORIZATION AND RELEASE

I hereby authorize release of information necessary to file claims with my insurance company and assign payments of the benefits I am entitled under the provisions of my policy to **Seth M. Hudson, D.C.** of Hudson Chiropractic at the Pillar Chiropractic Physicians Centre. In addition to the foregoing, I hereby authorize the release of my medical information by or between any of my treating physicians and my insurer, HMO, health benefits payor of any other entity (including but not limited to third party administrators, management companies and provider networks) involved in administration of my health benefits.

I understand I am financially responsible for payment of this account regardless of insurance or other third party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any collection fee and/or court costs.

Signature_____ Date _____/_____/_____

MEDICARE AUTHORIZTION AND RELEASE: Medicare patients ONLY

I request payment of authorized Medicare, Medigap, and/or any other insurance benefits be made to **Seth M. Hudson, D.C.** of Hudson Chiropractic at the Pillar Chiropractic Physicians Centre for any services furnished to me by the provider.

I understand my signature requests that payment be made and authorizes release of medical information necessary to determine benefits payable for services from this provider.

In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, non-covered services as ultrasound, electric muscle stimulation, traction, etc. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that I am finally responsible for all charges whether paid by said insurance or not. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and original.

Signature _____ Date _____/_____/_____

Name: _____

Please check the appropriate line for any of the following symptoms which you now have or had had previously. We want to know all of that facts about your health. This is a confidential health report.

OCCASIONAL FREQUENT

CONSTITUTIONAL

____ ____ Chills
____ ____ Drowsiness
____ ____ Fainting
____ ____ Fatigue
____ ____ Fever
____ ____ Night Sweats
____ ____ Weakness
____ ____ Weight Gain
____ ____ Weight Loss

EYES

____ ____ Blindness
____ ____ Blurred Vision
____ ____ Cataracts
____ ____ Change in Vision
____ ____ Double Vision
____ ____ Dry Eyes
____ ____ Eye Pain
____ ____ Field Cuts
____ ____ Glaucoma
____ ____ Sensitivity to Light
____ ____ Tearing
____ ____ Wears Glasses

CARDIOVASCULAR

____ ____ Angina
____ ____ Chest Pain
____ ____ Claudication
____ ____ Heart Murmur
____ ____ Heart Problems
____ ____ High Blood Pressure
____ ____ Low Blood Pressure
____ ____ Orthopnea
____ ____ Palpitations
____ ____ Shortness of Breath
____ ____ Swelling of Legs
____ ____ Varicose Veins

RESPIRATORY

____ ____ Asthma
____ ____ Bronchitis
____ ____ Dry Cough
____ ____ Productive Cough
____ ____ Coughing up Blood
____ ____ Difficulty Breathing
____ ____ Difficulty Sleeping
____ ____ Hemoptysis
____ ____ Pneumonia
____ ____ Sputum Production
____ ____ Wheezing

OCCASIONAL FREQUENT

MUSCULOSKELETAL

____ ____ Arthritis
____ ____ Neck Pain
____ ____ Decreased Motion
____ ____ Gout
____ ____ Injuries
____ ____ Joint Pain
____ ____ Joint Stiffness
____ ____ Locking Joints
____ ____ Back Pain
____ ____ Muscle Cramps
____ ____ Muscle Pain
____ ____ Muscle Twitching
____ ____ Muscle Weakness
____ ____ Swelling

INTEGUMENTARY

____ ____ Breast Lumps/Pain
____ ____ Change in Nail Texture
____ ____ Change in Skin Color
____ ____ Eczema
____ ____ Hair Growth
____ ____ Hair Loss
____ ____ History of Skin Disorders
____ ____ Hives
____ ____ Itching
____ ____ Paresthesia
____ ____ Rash
____ ____ Skin Lesions

ENMT

____ ____ Bad Breath
____ ____ Dentures
____ ____ Deviated Septum
____ ____ Difficulty Sleeping
____ ____ Difficulty Swallowing
____ ____ Discharge
____ ____ Dry Mouth
____ ____ Ear Drainage
____ ____ Ear Pain
____ ____ Frequent Sore Throat
____ ____ Head Injury
____ ____ Hearing Loss
____ ____ Hoarseness
____ ____ Loss of Smell
____ ____ Loss of Taste
____ ____ Nasal Congestion
____ ____ Nose Bleeds
____ ____ Post Nasal Drip
____ ____ Sinus Infections

OCCASIONAL FREQUENT

____ ____ Runny Nose
____ ____ Snoring
____ ____ Sore Throat
____ ____ Ringing in Ears
____ ____ TMJ Problems
____ ____ Ulcers

GASTROINTESTINAL

____ ____ Abdominal Pain
____ ____ Belching
____ ____ Black, Tarry Stools
____ ____ Constipation
____ ____ Diarrhea
____ ____ Heartburn
____ ____ Hemorrhoids
____ ____ Indigestion
____ ____ Jaundice
____ ____ Nausea
____ ____ Rectal Bleeding
____ ____ Abnormal Stool
____ ____ Vomiting
____ ____ Vomiting Blood

GENITOURINARY

____ ____ Frequent Urination
____ ____ Hesitancy/Dribbling
____ ____ Hormone Therapy
____ ____ Lack of Bladder Control
____ ____ Urine Retention
____ ____ Burning Urination

NEUROLOGICAL

____ ____ Change in Concentration
____ ____ Change in memory
____ ____ Dizziness
____ ____ Headache
____ ____ Imbalance
____ ____ Loss of Consciousness
____ ____ Loss of Memory
____ ____ Numbness
____ ____ Seizures
____ ____ Sleep Disturbances
____ ____ Slurred Speech
____ ____ Stress
____ ____ Strokes
____ ____ Tremors

OCCASIONAL FREQUENT

PSYCHIATRIC

____ ____ Agitation
____ ____ Anxiety
____ ____ Appetite Changes
____ ____ Behavioral Changes
____ ____ Bipolar Disorder
____ ____ Confusion
____ ____ Convulsions
____ ____ Depression
____ ____ Homicidal Indication
____ ____ Insomnia
____ ____ Location Disorientation
____ ____ Memory Loss
____ ____ Substance Abuse
____ ____ Suicidal Indication
____ ____ Time Disorientation

ENDOCRINE

____ ____ Cold intolerance
____ ____ Diabetes
____ ____ Excessive Appetite
____ ____ Excessive Hunger
____ ____ Excessive Thirst
____ ____ Goiter
____ ____ Hair Loss
____ ____ Heat Intolerance
____ ____ Unusual Hair Growth
____ ____ Voice Changes

HEMATOLOGIC/LYMPHATIC

____ ____ Anemia
____ ____ Bleeding
____ ____ Blood Clotting
____ ____ Blood Transfusions
____ ____ Bruise Easily
____ ____ Lymph Nose Swelling

ALLERGIES

____ ____ Seasonal Allergies
____ ____ Food Intolerance

Men Only:

____ ____ Prostate Problems
____ ____ Erectile Dysfunction

Women Only:

____ ____ Birth Control Therapy
____ ____ Cramps
____ ____ Abnormal Vaginal Bleeding
____ ____ Vaginal Discharge
____ ____ Pregnant
____ ____ Miscarriage

Have you had Breast Implants?
_____ Yes _____ No

Habits:
____ Alcohol ____ Coffee ____ Tobacco ____ Drugs

Have you tested positive for any communicable diseases? Ex. HIV, Syphilis, Gonorrhea _____ Yes _____ No

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD
CIRCLE ITEMS THAT ARE COMMON WITH OTHER FAMILY MEMBERS

____ Alcoholism	____ Diabetes	____ Gout	____ Goiter	____ Rheumatic Fever	____ Ulcers
____ Anemia	____ Eczema	____ Heart Disease	____ Cancer	____ Stroke	____ Foot Problems
____ Appendicitis	____ Emphysema	____ Multiple Sclerosis	____ Polio	____ Tuberculosis	_____Other

I hereby state that the above information is true, to the best of my knowledge.

Signed_____ Date: _____