Hailey Chiropractic, P.C.
Patient Information

Patient Name Last:_____ *First*:_____ *MI*:____

Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Which number would you prefer we call for appointment reminders and other communication? □ Home □Work □ Cell

Email Address: _____ Social Security number: _____

Sex: □ M □ F Marital Status: M S D W Age: _____ Date of Birth: _____

Occupation_____

Employer_____

Whom may we thank for referring you? _____

Emergency Contact:_____ Phone Number:_____

Have you ever received Chiropractic Care? □ Yes □ No If yes, when? _____

Name of most recent Chiropractor: _____

Personal Health History

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ High blood pressure □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

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Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naproxen/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Do you have a history of cancer: □ Yes □ No If yes, what type?
_____

Women: Are you pregnant? □ Yes □ No If yes, how many weeks?_____

Please list all medications you are currently taking:

_____
_____
_____

Please list all surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a history of any significant trauma/injuries or any broken bones? If yes, please briefly describe:

_____

Is there anything else in your past medical history that you feel is important to your care here? _____

Family Health History

Do you have a family history of?
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases □ Psychiatric disease
□ Cardiac disease below age 40 □ Diabetes □ Adopted/Unknown □ Other _____ □ None of the above

Cause of parents or siblings death Age at death

_____
_____
_____
_____

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Daily Habits

	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Tobacco	□	□	□	□
Recreational Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□

Current Symptoms

What is your primary reason for seeking chiropractic care?

_____

_____

Secondary reason: _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____

Please answer the following questions concerning your symptoms.

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the above symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptoms at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptoms begin? _____
    - Did the symptoms begin suddenly or gradually? (circle one)
    - How did the symptoms begin? _____
- What makes the symptoms worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at the waist, bending backward at waist, tilting left at waist, tilting right at the waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Andrea Hailey, D.C., for services performed. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs and attorney fees. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement.

Patient (or Guardian) Signature _____

Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____

CANCELLATION POLICY

We kindly request a 24 hour notice for all cancellations.

I understand that chiropractic visits not cancelled with adequate notice may be subject to the full visit fee of $45.

I also understand that massage therapy visits not cancelled with adequate notice will be subject to the full fee of the length of the massage scheduled.

Patient Initials _____ Date _____

Patient Name Last:_____ *First*:_____ *MI*:____

Hailey Chiropractic, P.C.
Andrea Hailey, D.C.
436 South Linden Avenue, Waynesboro VA
540-248-3210 540-416-0243 fax

I consent to receiving notifications by:

- ❑ Text:_____ Mobile Provider:_____
- ❑ Email:_____

Name:_____

Signature:_____

Date:_____

Appointment reminders are a courtesy and should not be relied upon. Failure to receive a reminder does not absolve patient from responsibility concerning their appointment.

You have the option to opt out of any of these methods at any time by notifying our office.

Email and standard SMS/text messaging are not confidential methods of communication and may not be secure.