

Michael D. Hanley, D.C.

Patient Demographics

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ **** Driver's License#: _____

Sex: M/F Marital Status: M S D W Name of Spouse: _____

Race: _____ Date of Birth: _____

*****Social Security numbers are required for billing and financial records if you choose not to provide this you will be required to pay, in full, for services at time of appointment and we will provide you with the proper documentation to submit to your insurance for reimbursement*

Contact Information (check preference)

Home# _____ Cell# _____ Work# _____

E-mail address: _____

Emergency Contact: _____ Phone# _____

Name of Employer: _____

Employer Address: _____

Occupation: _____

How were you referred to this office: _____

Type of Case

____ Private Insurance ____ Work Compensation ____ Cash

____ Personal Injury (Auto) ____ Medicare

Insurance Information

Insurance Name: _____ Phone#: _____

Policy Holder Name: _____ DOB _____

Policy#: _____ Claim#: _____

Adjustor/Agent Name: _____

Copy of Insurance Card:

Patient Name: _____ Date: _____

PROBLEM THAT YOU ARE BEING SEEN FOR TODAY:

1.	Date began: _____
2.	Date began: _____
3.	Date began: _____
4.	Date began: _____

VITALS: Height _____ Weight _____ Blood Pressure _____ Dom. Hand: R L AMD

Smoking: No Past Yes (heavy or light)

MEDICATION:

ALLERGIES:

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SURGERIES / HOSPITALIZATION (PLEASE CIRCLE ANY THAT APPLY AND WRITE IN DATE):

Date	Date	Date
Appendectomy	Pacemaker	Aortic Aneurysm
Cervical Fusion	Morphine pump	Carpal Tunnel
Lumbar Fusion	Defibrillator	Hip Replacement (THA)
Lumbar Discectomy	Spinal Stimulator	Knee Replacement (TKA)
Cataract (eye)	Ear Implant	Shoulder Replacement
Cardiac Stint	Heart By-Pass	Other: _____

MAJOR ILLNESS (PLEASE CHECK ANY THAT APPLY):

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headache	<input type="checkbox"/> Digestive Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Backache	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other: _____

LAB TESTS / X-RAYS / MRIS:

CHIROPRACTORS OR OTHER PHYSICIANS SEEN:

FAMILY HISTORY (CHECK ALL THAT APPLIES AND INDICATE WHO IT APPLIES TO)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back pain
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches

- Patient Education: Office use only
- Growth Chart: Office use only
- Counseled Weight Loss Recommendation BMI ≥ 25%: Office use only
- Counseled Stop Smoking Recommendation: Office use only
- Referral made: Office use only Preface Date Condition Date Illness Date
- G8783 - Normal BP G8950- Elevated BP

Lumbar Oswestry: _____
Neck Index: _____
Shoulder Disability Index: _____
Roland Morris: _____

Michael D. Hanley, D.C.
Accident/Injury Questionnaire

Name: _____ Date: _____ PT#: _____

Have you retained an Attorney? Yes No Name: _____

Address: _____ Phone#: _____

Please list names of any witnesses: _____

Accident Information

Date of Accident: _____	Time: _____	am	pm
Conditions (please circle): DRY WET ICY SNOW MUDDY			

Description of accident in your words:

Mechanism of Injury (please check all that apply)

<input type="checkbox"/> Vehicle	<input type="checkbox"/> Struck right side
<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Struck left side
<input type="checkbox"/> Pedestrian	<input type="checkbox"/> Right hand on steering wheel
<input type="checkbox"/> Driver	<input type="checkbox"/> Both hands on steering wheel
<input type="checkbox"/> Front seat passenger	<input type="checkbox"/> Left hand on steering wheel
<input type="checkbox"/> Rear seat passenger	<input type="checkbox"/> Air bag deployed
<input type="checkbox"/> Wear lap and strap support seat belt	<input type="checkbox"/> No air bag deployed
<input type="checkbox"/> Was unrestrained	<input type="checkbox"/> Vehicle had no air bag
<input type="checkbox"/> Passenger side impact	<input type="checkbox"/> Police and ambulance present
<input type="checkbox"/> Driver side impact	<input type="checkbox"/> No police report
<input type="checkbox"/> Rear impact	<input type="checkbox"/> Car spun upon impact
<input type="checkbox"/> Frontal impact	<input type="checkbox"/> Car rolled

Did any part of your body strike anything:

Example: Left side of head hit window / Forehead hit steering wheel

Please explain: _____

How did you feel at time of accident:

<input type="checkbox"/> Unconsciousness	<input type="checkbox"/> How long: _____	<input type="checkbox"/> Dizziness	<input type="checkbox"/> How long: _____
<input type="checkbox"/> Dazed	<input type="checkbox"/> How long: _____	<input type="checkbox"/> Nauseated	<input type="checkbox"/> How long: _____
<input type="checkbox"/> Confusion	<input type="checkbox"/> How long: _____	<input type="checkbox"/> Vomiting	<input type="checkbox"/> How long: _____
<input type="checkbox"/> Headache	<input type="checkbox"/> How long: _____	<input type="checkbox"/> Other:	<input type="checkbox"/> How long: _____

How did you leave the accident site:

	Drove
	Ambulance
	Friend
	Husband
	Wife
	Daughter
	Son
	Family Member
	Other:

Where did you go:

	Went to ER
	Went to work
	Went to home
	Other:

Treatment that you received at the hospital / ER:

List other Doctors seen and/or tests that you have received for this accident:

Doctor or Test	Date