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:_____

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 ____ Medicare

Insurance Information

Insurance Name:_____ Phone#:_____

Policy Holder Name_____DOB_____

Policy#:_____ Claim#: _____

Adjustor/Agent Name_____

Copy of Insurance Card:

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Health History

Name: _____Date:_____

Problem that you are being seen for today:

1.	When did it start:
2.	When did it start:
3.	When did it start:
4.	When did it start:
5.	When did it start:
6.	When did it start:

Have you had this or similar conditions in the past:
_____ When: _____

What activities aggravate your condition:

_____

Is your condition getting: Worse_____ Better _____ Same_____
Constant:_____ Comes and goes:_____

What doctors have you seen for the problems:

_____

What scans/tests/x-rays have you had for this problem and when?

_____

Do you currently smoke: YES NO Have you ever: YES NO

List the medications that you are taking:

_____

Please list any allergies you have:

_____

What x-rays have you had in the past two years:

_____

Have you had chiropractic care before: YES NO
If yes, please provide the name and locations:

_____

Is there any possibility that you might be pregnant: YES NO

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Health History

Family History (check all that apply)

	Diabetes		Arthritis		Back pain
	Stroke		High Blood Pressure		Neck pain
	Heart Disease		Cancer		Headaches

Personal History (check all that apply)

	Dizziness		Headache		Digestive Disorders
	Diabetes		Arthritis		Heart Trouble
	Anemia		Asthma		Rheumatic Fever
	Cancer		Backache		Tuberculosis
	Epilepsy		Stroke		Ringing in Ears
	Hepatitis		Eye Strain		High Blood Pressure

	Surgeries	Date		Surgeries	Date
	Appendex(Appendectomy)			Aortic Aneurysm	
	Cervical Fusion			Carpal Tunnel	
	Lumbar Fusion			Hip Replacement (THA)	
	Lumbar Discectomy			Knee Replacement (TKA)	
	Cataract (eye)			Shoulder Replacement	
	Cardiac Stint			Heart By-pass	
	Other:			Other:	

Have you had any implants: (check all that apply)

	Pacemakers		Spinal stimulator
	Morphine pump		Ear implant
	Defibulator		Other implanted metal

PAIN DIAGRAM

1. Use the appropriate symbols below to mark your areas of complaints.

Numbness	Pins & Needles	Throbbing	Burning	Aching	Stabbing
N	**P**	**T**	**B**	**A**	**S**

2. Rate your pain between 0--10 for EACH AREA.

0 1 2 3 4 5 6 7 8 9 10

No pain **Severe pain**