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:

Michael D. Hanley, DC
Patient History

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:

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):

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

LAB TESTS / X-RAYS / MRIS:

CHIROPRACTORS OR OTHER PHYSICIANS SEEN:

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

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