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: Yes____ **No**____ **Past**____ **(heavy or light)**

Are you pregnant: Yes____ **No**____

MEDICATION:

ALLERGIES:

SURGERIES / HOSPITALIZATION: (PLEASE CIRCLE ANY THAT APPLY AND WRITE IN 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:	XRAYS:	MRI'S:

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:______________

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, 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)

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

	Unconsciousness	How long:		Dizziness	How long:
	Dazed	How long:		Nauseated	How long:
	Confusion	How long:		Vomiting	How long:
	Headache	How long:		Other:	How long:

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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