Hanczaryk Chiropractic Neurology Group

8185 Holly Rd. Suite 14 Grand Blanc, Michigan 48439

Outline Procedures For New Patients

Step One: All new patients are requested to fill out a personal health questionnaire prior to their appointment.

Step Two: Your consultation with a doctor to discuss your health problems.

Step Three: Diagnostic: Chiropractic, Orthopedic, and Neurological examination procedures to determine if chiropractic care is appropriate for your condition.

Step Four: You will be advised if there is a need for any additional procedures such as x-rays, MRI, & CAT scan.

Step Five: If your case requires immediate attention, treatment will be administered.

Step Six: Upon completion of todays tests and exam procedures, you will be scheduled for a "Report of Findings: so that the doctor will inform you as to your examination results and whether or not your case has been accepted. At that time, you will be informed of specific recommendations in regards to your condition.

Step Seven: If appropriate, your treatment plan will begin following your "Report of Findings".

Confidential Patient Information

Name:_____ Social Security #:_____ Date:_____

Date Of Birth:_____ Age:_____ Sex: M F Height:_____ Weight:_____ Marital: M S W D How Many Children?_____

Race: Asian___ African American___ Caucasion___ Latin American___ Native American___ Pacific Islander___ Other___ Language:_____

Address:_____ City:_____ Zip:_____

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

Email:_____

Referred By: Patient (Name)_____ Physician (Name)_____

Ad (Location)_____ Other _____

Is your condition due to injury or sickness arising out of patient's employment? Y___ N___ Date of accident:_____

Date of last physical examination:_____ Female: Are you pregnant? Y_____ N_____

What operations have you had:_____

Serious Illnesses:_____ Fractured Bones:_____

Have you ever been under chiropractic care: Y_____ N_____ Doctor's Name:_____

In case of emergency contact:_____ Phone:_____

Work Status: Employed _____ Retired_____ Disabled_____ Full-Time Student_____ Part-Time Student:_____

Occupation:_____ Employer:_____

Employer Address:_____ City:_____ Zip:_____

Policy Holder:_____ Policy Holder's D.O.B.:_____

Contract #:_____ Group #:_____

Name of Insurance Company:_____ Phone:_____

Name of Spouse/Partner:_____ Occupation:_____

Employer:_____ Address:_____

Why Chiropractic ?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort **(Relief Care)**. Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses **(Corrective Care)**. Still, others want what is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being **(Comprehensive Care)**. Hanczaryk Chiropractic Neurology offers som some of thelatest advanced procedures for optimizing your nervous system function. Hanczaryk Chiropractic Neurology Group stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice and your Doctor willweigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief Care_____ Corrective Care_____ Comprehensive Care_____ I would like to discuss my options with the doctor_____

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Complaint # 1

When did you first notice this condition?_____

_____

What is the exact location of your symptoms?_____

Do your symptoms radiate? If yes, where?_____

How often are you experiencing these symptoms?

Constantly_____ **Frequent (75%)**_____ **Often (50%)**_____ **Rarely (25%)**_____

Is this condition: **Worsening**_____ **Improving**_____ **Remaining Unchanged**_____

What is the intensity of your symptoms? **Severe**_____ **Mild**_____ **Moderate**_____

Rate your symptoms on a scale of 1-10, **considering 1 (minimal) and 10 (severe/excruciating)**_____

Is your pain **superficial**_____ or **deep**_____

Please indicate the character of your pain:

Dull_____ **Sharp**_____ **Burning**_____ **Aching**_____ **Knife-Like**_____ **Throbbing**_____

Are you experiencing any of the following associated symptoms?

Dull_____ **Sharp**_____ **Burning**_____ **Aching**_____ **Knife-Like**_____ **Throbbing**_____ **Pins & Needles**_____

Pins & Needles _____ **Tingling** _____ **Numbness**_____ **Twitching of Muscles**_____

If yes, please describe _____

_____

_____

Please indicate what activities Provoke (P) or Aggravate (A) your condition:

Sitting _____ Standing_____ Walking _____ Lying_____ Lifting_____ Pushing_____

Pulling_____ Gripping_____ Hot/Cold_____ Coughing/Sneezing_____ Mental Activities_____

Bright Lights _____

Other:_____

Please indicate what helps you to relieve the pain:

Sitting_____ Standing_____ Walking_____ Lying_____ Heat/Cold_____ Rest_____ Medications_____

_____

**********Please DO NOT write below this line**********

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Complaint # 2

When did you first notice this condition?_____

_____

What is the exact location of your symptoms?_____

Do your symptoms radiate? If yes, where?_____

How often are you experiencing these symptoms?

Constantly_____ **Frequent (75%)**_____ **Often (50%)**_____ **Rarely (25%)**_____

Is this condition: **Worsening**_____ **Improving**_____ **Remaining Unchanged**_____

What is the intensity of your symptoms? **Severe**_____ **Mild**_____ **Moderate**_____

Rate your symptoms on a scale of 1-10, **considering 1 (minimal) and 10 (severe/excruciating)**_____

Is your pain **superficial**_____ or **deep**_____

Please indicate the character of your pain:

Dull_____ **Sharp**_____ **Burning**_____ **Aching**_____ **Knife-Like**_____ **Throbbing**_____

Are you experiencing any of the following associated symptoms?

Dull_____ **Sharp**_____ **Burning**_____ **Aching**_____ **Knife-Like**_____ **Throbbing**_____ **Pins & Needles**_____

Pins & Needles _____ **Tingling** _____ **Numbness**_____ **Twitching of Muscles**_____

If yes, please describe _____

_____

_____

Please indicate what activities Provoke (P) or Aggravate (A) your condition:

Sitting _____ Standing_____ Walking _____ Lying_____ Lifting_____ Push Bright Lights _____

Pulling_____ Gripping_____ Hot/Cold_____ Coughing/Sneezing_____ Mental Activities_____

Bright Lights _____

Other:_____

Please indicate what helps you to relieve the pain:

Sitting_____ Standing_____ Walking_____ Lying_____ Heat/Cold_____ Rest_____ Medications_____

Other:_____

_____

**********Please DO NOT write below this line**********

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Confidential Patient Information Cont.

Family History: **Have any of your family members ever suffered from the following conditions?**

☐ Diabetes ☐ Neurological Disorders ☐ Depression/ Mental Illness ☐ Cancer

☐ Heart Disease ☐ Autoimmune Disorders ☐ Stroke ☐ Other _____

Medications: Please List your current medications and what they are taken for _____

_____

Vitamins and Minerals: **Do you take any vitamins/minerals? YES_____ NO_____**

If your answer is NO, do you think you may need them? YES_____ NO_____

Are you currently wearing of have ever worn: Inner Soles: YES_____ NO_____ Heel Lifts: YES_____ NO_____

Sole Lifts: YES_____ NO_____ Arch Supports: YES_____ NO_____

Habits:	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐	Exercise	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	Sleep	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	Appetite	☐	☐	☐	☐
Drugs	☐	☐	☐	☐					

HAVE YOU EVER SUFFERED FROM THE FOLLOWING: PLEASE CHECK ALL THAT APPLY.

☐ Low Blood Pressure	☐ Low Back Pain	☐ Difficulty Digestion	☐ Stroke	☐ Eye Pain	☐ Varicose Veins
☐ High Blood Pressure	☐ Sciatica	☐ Hemorrhoids	☐ Chest Pain	☐ Failing Vision	☐ Bed-Wetting
☐ Allergy	☐ Neck Pain/Stiffness	☐ Nausea	☐ Difficulty Breathing	☐ Tuberculosis	☐ Frequent Urination
☐ Headache	☐ Poor Posture	☐ Dizziness	☐ Swelling of Ankles	☐ Bruise Easily	☐ Kidney Infection/Stone
☐ Loss of Sleep	☐ Spinal Curvatures	☐ Fatigue	☐ Sinus Infection	☐ Hay Fever	☐ Prostate Trouble
☐ Ulcers	☐ Swollen Joints	☐ Pain Over Heart	☐ Asthma	☐ Nose Bleeds	☐ Alamps or Backache
☐ Numbness	☐ Venereal Disease	☐ Poor Circulation	☐ Colds	☐ Cancer	☐ Excessive Menses
☐ Arthritis	☐ Nervous Depression	☐ Rapid Heart Beat	☐ Deafness	☐ Pleurisy	☐ Hot Flashes
☐ Bursitis	☐ Colon Trouble	☐ Slow Heart Beat	☐ Ear Noises	☐ Spitting	☐ Irregular Cycle
☐ Foot Trouble	☐ Diarrhea	☐ Anemia	☐ Enlarged Thyroid	☐ Itching	☐ Lumps in Breast
☐ Alcoholism	☐ Diabetes	☐ Glaucoma	☐ Autoimmune Disease	☐ Mental Disorders	☐ Balance/Coordination
☐ Epilepsy	☐ Polio				

Family Doctor _____ **Address**_____

Family Doctor's Phone & Fax # _____

Would you like us to send a report? Yes_____ No_____

Payment is expected at time of service.

Name of person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Hanczaryk Chiropractic Neurology Group will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to HCNG will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I will be paying today by: Cash____ Check____ Credit Card____

Card Name & #:_____ Expiration Date:_____

Patient's Signature:_____ Date:_____

Information Taken By: _____ Date:_____