

# ABOUT THE PATIENT

HOYER CHIROPRACTIC

21 South 6<sup>th</sup> Street Estherville, IA 51334

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender  M  F  
 Significant Other's Name \_\_\_\_\_ Kid's Names and Ages \_\_\_\_\_  
 Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before?  No  Yes  
 Emergency Contact \_\_\_\_\_ ph # \_\_\_\_\_  
 Name of Medical Doctor(s) \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Hoyer Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:  Cash  Check  Credit Card  Car/Work Ins.

Patient / Parent Signature \_\_\_\_\_ (This represents a long term authorization for all occasions of service) \_\_\_\_\_ Date \_\_\_\_\_

## REASON FOR SEEKING CARE

### PRESENT COMPLAINTS

1. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
  2. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
  3. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
  4. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_
5. Does your condition affect:  Sleep  Work  Daily Routine  Sitting  Driving
6. What makes it better? \_\_\_\_\_
7. What makes it worse? \_\_\_\_\_
8. What Doctor's have you seen for this? \_\_\_\_\_

9. Type of treatment: \_\_\_\_\_

10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are you pregnant?**

Yes  No

