Please fill form in completely.
Thank you.

Welcome To Hansen Chiropractic

Referred By: _____

Name: _____ **Birthdate:** _____ **Sex: M F**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: ( ) _____ **Cell: ( )** _____ **Married____ Single____ Other____**

Email: _____ **Occupation:** _____

Employer: _____ **Work Phone: ( )** _____

Primary Care Physician Name: _____

Physician's Phone#: ( ) _____

Emergency Contact: _____ **Phone#: ( )** _____

Insurance

Do you have coverage for chiropractic or massage therapy? Y N

Subscriber's Name: _____ Birthdate: _____

Primary Ins. Company: _____ Phone#: ( ) _____

Group#: _____ Policy#: _____

Secondary Ins. Company: _____ Phone#: ( ) _____

Group#: _____ Policy#: _____

Please check / circle all of the following that apply to you:

Yes	No	Condition	Yes	No	Condition
☐	☐	Recent Trauma	☐	☐	High Blood Pressure
☐	☐	Recent Infection	☐	☐	Epilepsy or Seizures
☐	☐	Recent Fever	☐	☐	Diabetes
☐	☐	Recent Skin Rash	☐	☐	Dizziness or Fainting
☐	☐	Cancer or Tumor	☐	☐	Visual Disturbances
☐	☐	Varicose Veins	☐	☐	Urinary Problems
☐	☐	Heart or Vascular Disease	☐	☐	Pain in Neck / Back
☐	☐	Headaches or Migraines	☐	☐	Sensitivities / Allergies
☐	☐	GI Problems	☐	☐	Alcohol Use
☐	☐	Tobacco Use	☐	☐	Recreational Drug Use
☐	☐	Numbness, Tingling or Weakness of the Arms / Hands or Legs / Feet.			

Detail: _____

Recent Surgeries or Medication(s): _____

I certify that all the information above is complete and accurate. Should any of this health information change, I will notify Dr Hansen at the next time of visit. I understand that I am responsible for all charges for services rendered, regardless of insurance coverage. I agree to notify Hansen Chiropractic should my coverage change, and agree to allow authorized entities within Hansen Chiropractic to divulge any information required to process my claims with third-party payers.

Patient Signature: _____ **Date:** _____

2000 Cal Young Rd., Ste. D
Eugene OR 97401
(541) 343-6220

Revised 3/13

Hansen Chiropractic
(541) 343-6220

Patient Symptom Questionnaire

2000 Cal Young Rd. , Ste. D
Eugene, OR 97401

Patient's Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. When did your symptoms start? _____ day(s) week(s) month(s) year(s) unknown
2. Describe your symptoms and how they began: _____

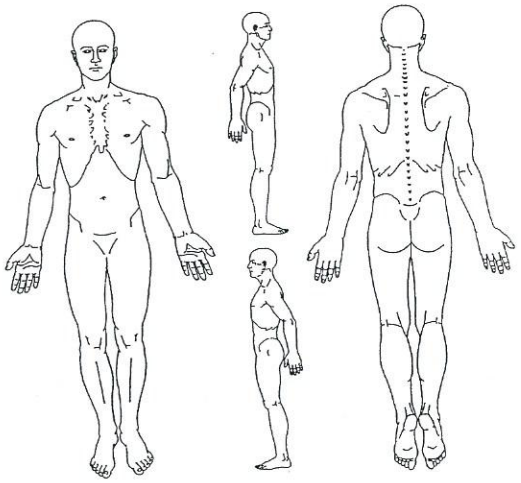
_____

_____

3. How often do you experience your symptoms?

   a) Constantly (76-100%)
   b) Frequently (51-75%)
   c) Occasionally (26-50%)
   d) Intermittently (0-25%)

Indicate *in detail* where you have symptoms:
Use arrows to show referred pain.



4. What describes the nature of your pain?

   a) Sharp f) Numb j) Other
   b) Stabbing g) Tingles
   c) Aches h) Shooting
   e) Burns i) Weakness

5. Are your symptoms ….

   a) Getting worse
   b) Not changing
   c) Getting better

6. How bad are your symptoms at their:

	none										unbearable
Worst	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

7. How do your symptoms affect your ability to perform daily activities?

_____

_____

8. What activities make your symptoms worse? _____
9. What activities make your symptoms better? _____
10. Who else have you seen for this problem? _____
    When was the last treatment? _____
    What type of treatment was performed? _____
11. Have you had similar symptoms in the past? _____ How long ago? _____
    What treatment did you receive then? _____
12. Are you taking any prescription or natural drugs? _____
13. What is your occupation? _____ Part-time Full-time
14. Please describe anything that you feel is relevant to this condition: _____

_____

_____

15. What do you wish to gain from your visit /treatment *(select all that apply):*
    ___ Reduce symptoms ___ Explanation of condition ___ Prevention of this condition
    ___ Resume/increase activity ___ Learn to take care of this on my own.

Patient Signature _____ Date _____

Hansen Chiropractic
(541) 343-6220

2000 Cal Young Rd., Ste. D
Eugene OR 97401

Patient Health Questionnaire-Pg.2

Patient Name: _____ **DOB:**_____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Frequent Urination
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular incoordination
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Tinnitus (ear noises)
☐	☐	Cancer
☐	☐	Tumor
☐	☐	High Blood Pressure

Past	Present	
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Rapid Heart Beat
☐	☐	Angina
☐	☐	Aortic Aneurysm
☐	☐	Blood Disorder
☐	☐	Kidney Stones
☐	☐	Aortic Aneurysm
☐	☐	Bladder Infection
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostrate Problems
☐	☐	Abnormal Weight gain/loss
☐	☐	Anorexia
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Difficulty Swallowing
☐	☐	Constipation
☐	☐	Heartburn/Indigestion
☐	☐	Ulcer
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder disorder

Past	Present	
☐	☐	Emphysema
☐	☐	Asthma
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Drug/Alcohol Dependence
☐	☐	Excessive Thirst
☐	☐	Knee/Lower Leg Pain
☐	☐	HIV/AIDS

Females Only:

☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast Soreness/Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	Dyspareunia

Indicate if an immediate family member has had any of the following:

☐ Chronic Back Problems ☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ Cancer ☐ Lupus
☐ Chronic Headaches ☐ Lung Problems ☐ Heart Problems ☐ Diabetes ☐ Other

Do you have a permanent disability rating? ☐ Yes ☐ No Rating % _____ Date Rec'd _____

Describe your disability:_____

_____

List all prescriptions, over-the-counter meds, and natural meds you are taking: _____

_____

List all surgical procedures and dates, and dates/reasons you have been hospitalized: _____

_____

Patient Signature:_____ Date: _____

_____

Doctor's Additional Comments: _____

_____

Doctor's Signature: _____ Date: _____
Author of Record

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient _____

Please review the below-listed diseases and conditions and indicate those that are health problems in a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( )Age( )	SISTER(S) Age( )Age( )	CHILDREN Age( )Age( )Age( )
Arthritis						
Asthma/Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

_____

Hansen Chiropractic
2000 Cal Young Rd., Ste. D
Eugene, OR 97401

Consent to Treat

Chiropractic is the art & science of enhancing the body's ability to heal itself and work at the most optimum level available. To accomplish this task, chiropractors use physical examination methods (orthopedic tests, neurological tests, physical examination - all requiring physical contact)) and manipulation methods (also requiring physical contact) to effect joints, nerves & soft tissues. Adjusting techniques incorporate hand, arm and upper body contact with the patient to effect movements in the joints & soft tissues. Treatment with soft tissue techniques (i.e., massage) and certain physiotherapies usually requires exposure of the skin in the affected areas to deliver these modalities.

Cervical Adjusting & Stroke – Unbiased medical literature and research has shown no correlation between cervical adjusting and increased risk of stroke when compared to services rendered by a MD for neck symptoms. However, patients with certain cardiovascular diseases (increased plaque, clotting issues, transient vertebral artery dissections, etc) may be predisposed to embolisms which may cause TIA's or stroke. Literature on this can be found in the reception area and on the wall in the treatment room #1. If you have any such condition(s), inform the doctor before care begins.

If you have any questions or concerns, please share them with me *before or during* treatment. I will try to explain any treatment modalities before beginning a regime. You understand that no guarantee is made regarding the safety of the treatments or the results. As with any forms of healthcare, there are some risks, rare though they are, with chiropractic care.

You understand you have been informed about possible adverse reactions to treatments and have been encouraged to communicate with Dr. Hansen about any issues/concerns you have regarding your treatments. Your signature indicates your acceptance and consent to treat the conditions with which you are seeking help with.

_____ _____
Name Date

_____
Signature

Billing Policy

As a courtesy, this office will bill your insurance company. Billing will be done monthly. Patients are responsible for any unpaid amount not covered by their insurance company, unless the provider contract with the insurance company states otherwise.

Payment from patients on a monthly billing cycle is expected within 7 days from receipt of the billing.

This office will work with any patients experiencing financial difficulties within reasonable limits. It is up to the patient(s) to contact this office to set up payment plans.

_____ _____
Patient Signature Date