HH Chiropractic @ Sun City
300 New River Parkway, 22
Hardeeville, SC 29927
843-208-3404

# PATIENT HISTORY

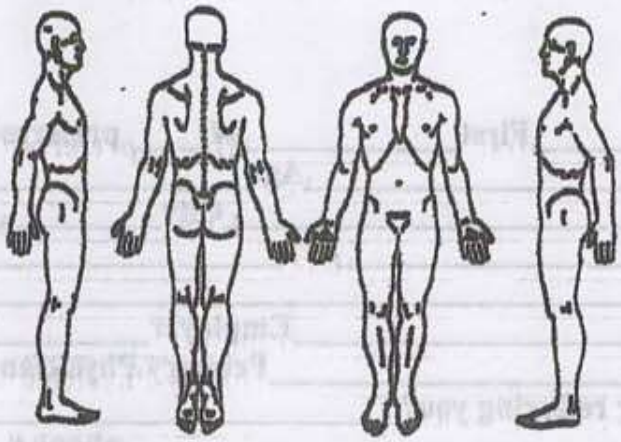
(Please answer all questions)

Last _____ First _____ MI ___ preferred Name _____
Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (C) _____
Email _____
Occupation _____ Employer _____
Spouses Name _____ Primary Physician _____
Who may we thank for referring you? _____
Emergency Contact _____ phone # _____
Last time you went to a DOCTOR OF CHIROPRACTIC? _____
Chiropractic techniques you have had success with _____
Other doctors who have treated this problem? _____
Surgeries _____
Medications you currently take _____
(we can copy a list if you have them)
Do you know what a subluxation is? _____
What daily rituals for spinal health do you presently practice?
_____
Primary Complaint is: _____

Date when symptoms appeared _____ how did it begin: Gradual Sudden Progressive
Cause of condition if known. _____
Did you have similar symptoms prior to this episode? _____
What makes your symptoms increase? _____
What relieves your symptoms? _____

Type of pain: circle all that apply: Achy Burning Dull Numbness Radiating
Sharp Shooting Spasm Stiff Throbbing Tingling Weakness
How often do you experience these symptoms? Occasionally Frequently Constantly
Does the pain radiate? _____ where _____
Rate the intensity of your symptoms on a scale of 1-10
(1 being no pain, 10 being extreme: _____
Please list any treatments for above condition(s) _____
Do you have any family members who suffer from the same complaint? _____
What are the main activities your complaint(s) inhibit you from doing? _____
_____
Please use second sheet for any Secondary or Tertiary Complaints

Please mark the areas of your complaint



**CONSENT TO TREAT:** **I HEREBY AUTHORIZE HH CHIROPRACTIC @ SUN CITY doctors and their assistants to perform examinations, therapeutic modalities, and/or diagnostic testing (X-rays) and other treatment that is medically necessary to me or a minor I am legally responsible for today and throughout the course of my treatment plan. INITIAL_____**

**ASSIGNMENT AND RELEASE:** **I certify that I, or my dependent(s), have insurance coverage and assign directly to HH Chiropractic @ Sun City all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above names insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. INITIAL_____**

**Office Policy is to have a credit card on file**

**Master Card Visa American Express Discover**

**Card #_____ Exp. Date:_____ V Code_____**

**SIGNATURE_____ DATE_____**