

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 today's 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 ___ Caucasian ___ 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 some of the latest 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 will weigh 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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Confidential Patient Information Cont.

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

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Depression/ Mental Illness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Stroke | <input type="checkbox"/> 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 _____

<u>Habits:</u>	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

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

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

Patient's Signature: _____ **Date:** _____

Information Taken By: _____ **Date:** _____