Terry M. Hambrick, DC

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CONFIDENTIAL INTRODUCTORY PATIENT INFORMATION

Date: _____Email: _____

Name: _____SS#:_____Phone#_____

Address:_____ City#:_____State:_____Zip:_____

Age:_____Sex:_____Birthdate:_____ Marital Status: M S W D Name of Spouse:_____

Children:_____Ages:_____

Occupation:_____Employer:_____ Phone #:_____

Contact in emergencies:_____ Phone #:_____

Who may we thank for referring you?_____

Is the condition for which you seek care arising out of employment?: Yes_____No_____

Are you seeking care for an accidental injury? Yes_____No_____Type_____

What is the health problem for which you are seeking care today?_____

_____

How will you know when you are better?_____

When did the problem first appear:_____What relieves it?_____

Is it getting worse, staying the same, or getting better?_____What makes it worse?_____

Has it affected your daily living? (work, sleep, exercise, etc.) If so, how?_____

What treatments have you had for this condition?_____

Name of family physician_____Address_____

List the medications you are taking:_____

List dates and types of surgeries you have had:_____

Date of last physical exam:_____Results:_____

Have you been under chiropractic care before? If so, when?_____

Doctor's name and address:_____

Have you had any serious injuries in the past year? If so, please list:_____

_____

Any broken bones?_____

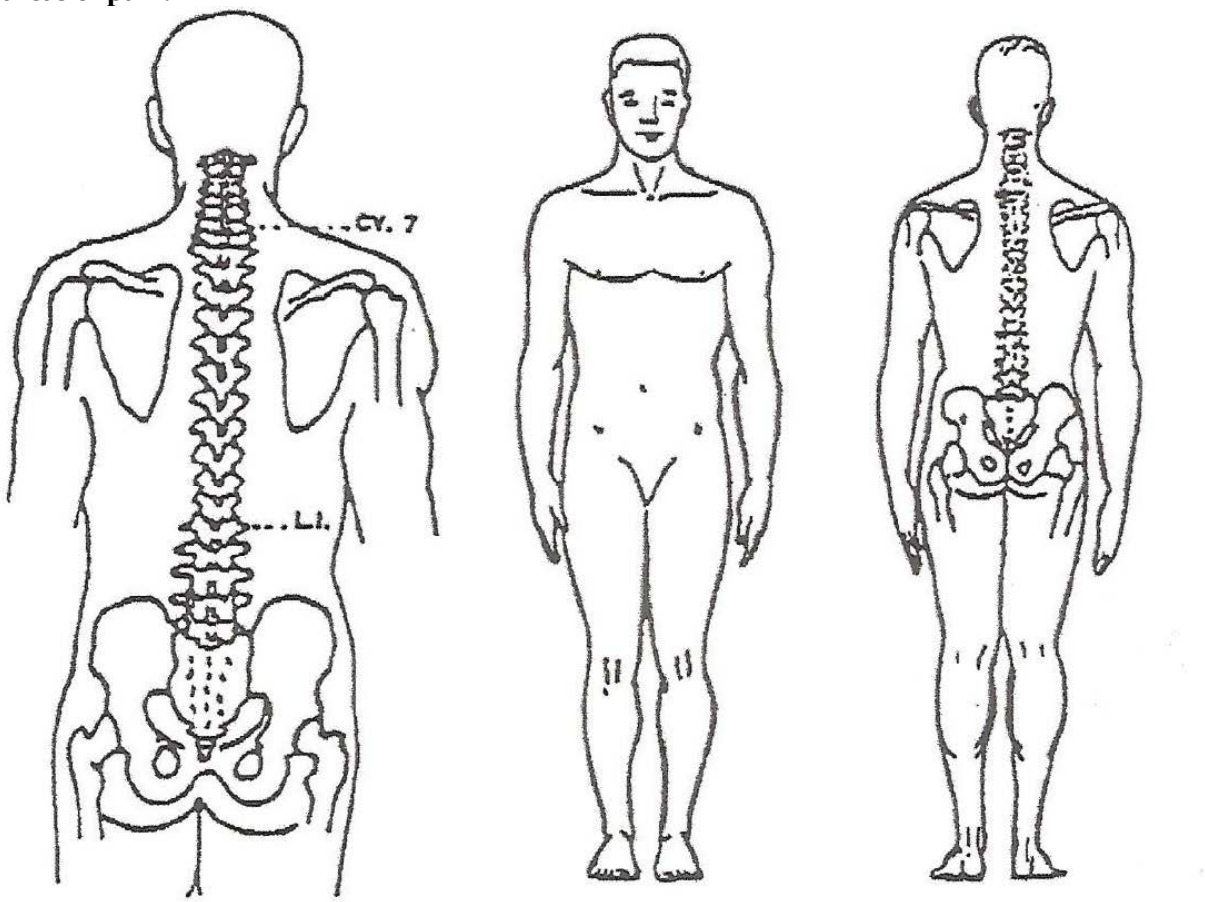
Are you wearing heel lifts?:_____Arch supports?_____Sole lifts?_____

Females: Are you pregnant? If so, due date:_____Any complications?_____

List any additional information which would help us better understand your condition_____

_____

Mark the areas of pain:



I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give 24 hours advance notice of cancellation. Furthermore, I understand and agree that my health and accident insurance policies are an arrangement between my insurance carrier and myself. Any insurance proceeds inadvertently paid directly to Dr. Hambrick will be credited to my account and any balance refunded to me. I hereby authorize Dr. Hambrick to release any information related to his diagnosis and treatment of me to any insurance agency, attorney, attending physician or employer in order to properly administer the dispensation of my case. I acknowledge that Medicare may not cover these services.

_____

Patient's Signature

DR TERRY M. HAMBRICK
Confidential Introductory Patient Information

Name_____ Date_____

How often do you have bowel movement? _____How many times daily? ___
How often do you have diarrhea or loose stools? _____
How often do you suffer or have symptoms directly attributed to, or connected with constipation? _____

What foods do you crave and when? _____

_____

Have you noticed an unexplained loss of sense of smell and/or taste? _____

After a meal, do you get; gas_____ bloating _____ belching_____
If so, when in relationship to the end of the meal;
Immediately _____ 20-30 minutes_____ 1-2 hours_____ Other_____

Do you get sluggish or sleepy after a meal? _____

Have you noticed this symptom being worse with any particular food or type of meal? _____

Are there any foods that you know are allergic or to which you have intolerance or sensitivity? _____

Do you have any symptoms that occur on a monthly or cyclic basis? _____ If so, please list them: _____

In the process of getting well, what percent of the responsibility do you think is your own? _____

What percent of the responsibility is the Doctor's? _____

Does anyone else have the responsibility for getting you well?_____

Is there anything you are unwilling to change for the better, do differently, or give up in order to get well?_____

What has prevented you from getting well in the past?_____
_____

What do you think is a reasonable time frame in which to reach satisfactory resolution of your primary complaint?_____

Please list the specific therapies, remedies and/or treatments that you have tried that:

1. Have helped and continue to help._____

_____

2. Have been ineffective._____

_____

3. Helped at first but no longer do._____

_____

4. Have made you worse or aggravated your condition._____

_____

5. Have been suggested or prescribed but you did not follow._____

_____

Are you aware of anything or anyone that will prevent you from following a course of treatment to reach your health goals and resolve your primary complaint?_____

_____