HEALING HANDS CHIROPRACTIC

3054 B Berkmar Dr, Charlottesville, VA 22901
Dr. Angela Ference

Patient Information:

Date:
Name:
Birth Date:
Address:
City: State: Zip:
Email:
Sex: __M ___F Age:
Height: Weight:
__Married /Partnered for__years __# Marriages __Widowed
__Single __Minor __Single __Minor __Separated __Divorced
Occupation: Past:
Employer/School:
Employer's Tel #:
Employer's Address:
Spouse's Name:
Spouse's Birth Date:
Spouse's Employer:
Dependants:
Name(s)/Age(s):

Name of Responsible Party:_____
Relationship to Patient:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Angela Ference 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. Dr. Ference may use my health care information and my disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

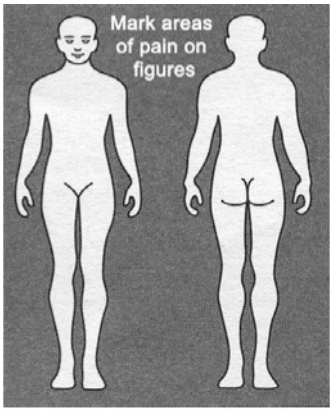
_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home:
Cell:
Best time to reach you:

IN CASE OF EMERGENCY, CONTACT:

Name:
Relationship:
Home Phone:
Other Phone:



Patient Condition:

Mark an **X** on the diagram where you have symptoms:
Reason for Visit/Chief Complaint:_____
When did your symptoms appear?_____What happened?_____
Is this condition getting progressively: __Better __Worse __Unknown
Rate the severity of your symptoms on a scale from 1 (least pain) to 10 (severe pain):
__Sharp __Dull __Throbbing __Numbness __Aching __Shooting
__Burning __Tingling __Cramps __Stiffness __Swelling __Other:_____
How often do you have these symptoms: ___100% __80% __50% __25% of the day?
Is it worse: __am __pm __with activity __resting
Activities or movements that are painful to perform: __Sitting __Standing __Bending __Lying Down __Sex
Rate (0-none, 10-worst) how it effects your: __Work __Sleep __Daily Routine __Recreation __Family __Sex Life
What treatment have you already received for this condition? __Medications __Surgery __Physical Therapy
__Chiropractic __Nutritional __None
Other_____
Have you had this problem before?

Name and address of other doctor(s) who have treated you for this condition:_____

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Patient Name: **Date:**

HEALTH HISTORY:

Date of Last:	Physical Exam:	Spinal X-Ray:	Blood Test:	MRI, CT Scan, Bone Scan:
	Urine Test:	Dental X-Ray:	Spinal Exam:	

PLEASE INDICATE IF *YOU* HAVE HAD ANY OF THE FOLLOWING:	**YES**	**NO**
AIDS/HIV		
Alcoholism		
Allergy Shots		
Anemia		
Anorexia		
Appendicitis		
Arthritis		
Asthma		
Bleeding Disorders		
Breast Lump		
Bronchitis		
Bulimia		
Cancer		
Cataracts		
Chemical Dependency		
Chicken Pox		
Diabetes		
Emphysema		
Epilepsy		
Fractures		
Glaucoma		
Goiter		
Gonorrhea		
Gout		
Headaches		
Heart Disease		
Hepatitis		
Hernia		
Herniated Disc		
Herpes		
High Blood Pressure		
High Cholesterol		

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:	**YES**	**NO**
Kidney Disease		
Liver Disease		
Measles		
Migraine Headaches		
Miscarriage		
Mononucleosis		
Multiple Sclerosis		
Mumps		
Osteoporosis		
Pacemaker		
Parkinson's Disease		
Pinched Nerve		
Pneumonia		
Polio		
Prostrate Problem		
Prosthesis		
Psychiatric Care		
Rheumatoid Arthritis		
Rheumatic Fever		
Scarlet Fever		
Sexually Transmitted Disease		
Stroke		
Suicide Attempt		
Thyroid Problems		
Tonsilitis		
Tuberculosis		
Tumors, Growths		
Typhoid Fever		
Ulcers		
Vaginal Infections		
Whooping Cough		
Other		

Family History of: __Diabetes __Heart Disease __Stroke __Cancer __MS __Depression __Arthritis
Details(age/relation)_____
Medications:_____
_____
Supplements: __Multi Vits __Fish Oils __Vit D __Magnesium __Calcium __Minerals
Other:_____
Diet: __Vegan __Vegetarian __Meat __Junk Other:_____

FOR DC USE ONLY:

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STRESSORS: **Patient Name:** _____ **Date:** _____

PHYSICAL Stress:

Birthing Stress-**your birth** (not of your child): __Forceps __Ventouse__Epidural __C-section __	
# Pregnancies: __ # Deliveries :__ # Children:__	
Birthing Stress-**giving birth to a child**: __Forceps __Ventouse __Epidural __C-section	
Exercise: __None __Moderate __Daily __Heavy / TYPE:_____	
Work: __Sitting __Standing __Light Labor __ Heavy Labour	
Amount of Sleep: __Little __Some __Moderate __Loads __# hours	
Sleep Position: __stomach __right side __left side __back / __ortho pillow __fluffy pillow __no pillow	
Sexual Activity: __Daily __Weekly __ Monthly (confidential)	
Falls:	Head Injuries:
Fractures/Dislocations:	Surgeries:
Hospital Visits:	MVAs:

CHEMICAL Stress:

Smoking: __ Packs/Day for __ Years
Alcohol: __Mixed Drinks __Beer __ Wine per week
Caffeine: __ Cups Coffee __Colas __Red Bull __ Cups Black Tea per week
Sugar: __very little __some __moderate __a lot
Do you eat: __not much __regularly __a lot __binge __vomit after eating __healthy __junk __vegies __meat
Food intolerances: __Dairy __Wheat/Gluten __Other:
Allergies: Toxic/Hazardous Waste Exposure:
Prescription Medications: __number of meds per month for __ years
Recreational Drugs (list and specify years of use):

MENTAL/EMOTIONAL Stress related to:

Work: __low __medium __high	Anxiety/Nervousness: __low __moderate __high
Travel/Commute: __low __medium __high	
Financial: __low __medium __high	Hobbies:
Family: __low __medium __high	
Intimate Relationship: __low __medium __high	
Physical Body: __low __medium __high	
Concern about current health: __low __medium __high	

HOW MAY WE HELP YOU?:

What is your main concern overall?
How do you gauge your health?
How will you gauge whether you improve with Chiropractic Care over the course of your treatment?
Is there anyone that you would like to bring with you to your chiropractic appointment that would offer you the opportunity to have the Chiropractor speak directly with them regarding your health and answer any of their questions? ___no ___yes, name: _____
Are you interested in making changes to improve your health?
Is there any topic mentioned above where your answer surprised you?
Is there any topic mentioned above that concerns you?
Is there anything you would like advice or more information on, whether it is a service we provide or we can recommend you to?

Thank you for taking the time to tell us how we may be of service to you.
We look forward to helping you achieve the level of health you desire.