Hanna Wellness Center
27791 La Paz Road | Laguna Niguel, CA
www.HannaChiropracticWellnessCenter.com
949.389.0400

Patient Intake Form

Please give your insurance card and license to our front desk to photocopy (if applicable)

PLEASE PRINT CLEARLY: Date: _____

Full Name: _____ DOB: _____ Age:_____ Gender: M F

Address:_____ City:_____ State:____ Zip: _____

Telephone: (____) _____ cell home work E-mail:_____

Appointment Reminders: Text –Cell Carrier _____ OR Email

Marital Status: S M D W # of children____ Work Status: FT PT Retired Student

Social security #_____ Driver's License # _____

Employer:_____ Occupation: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: (_____) _____

Person Responsible for account: _____

*Which doctor/practitioner are you here to see today? (Circle One):

Dr. Hanna Dr. Wendy Dr. Julie Other: _____

*How did you hear about us? (Circle One): Referred by: _____

Internet Friend: _____ Social Media: _____ Other: _____

MEDICAL INFORMATION/HISTORY

Primary Complaint & Health Concerns:

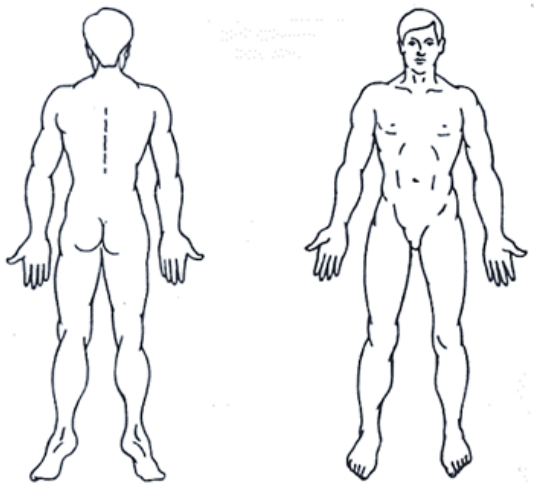
1._____
2._____
3._____

Current Medications:
(Please list dosage, frequency, and what it is for):

_____
_____
_____
_____

Allergies:

_____
_____
_____



Please indicate where you are feeling discomfort

Treatment: What type of treatment are you looking for? Symptom Relief Correctional Care Total Wellness

Symptoms/Complaints:(Relating to your primary complaint(s)):

- When did your symptoms begin? _____ What initiated the symptoms? _____
- Rate & describe your pain/discomfort on a scale of 0-10 (0 – no pain, 10 – worst) _____
- Have you previously been treated for this condition by another provider? Y N
  - If yes, then by whom? _____Treatment received: _____
- Have you had any reactions to previous treatment? Y N Describe:_____
- Has it worsened over time? Y___ N___ Same___ How long does it last?:_____
- Does it interfere with your: Sleep___ Daily Routine:___ Work ___
- What makes it worse? Standing Sitting Lying Bending Lifting Twisting Other: _____
- What has helped your pain/discomfort? :_____
- Do you have other conditions or symptoms that may be related your current symptoms? Y___ N___ If yes, what?
  _____

Have you ever been in an auto accident or other physical trauma? Never___ Past Year___ 1-5 Years___ 5+ Years___

Please Describe: _____

Indicate your symptoms by checking *P= Prior Condition or C=Current Condition.*

P	C		P	C		P	C		P	C	
_	_	Headache	_	_	Abdominal Pains	_	_	Paralysis	_	_	Fascial Pain
_	_	Nausea/Vomiting	_	_	Shakiness	_	_	Blurred Vision	_	_	Poor Appetite
_	_	Sweating	_	_	Dizziness	_	_	Fullness of Bladder	_	_	Insomnia
_	_	Earache	_	_	Urination Difficulty	_	_	Fainting	_	_	Eye Pain
_	_	Frequent Urination	_	_	Convulsions	_	_	Forgetfulness	_	_	Constipation
_	_	Irritability	_	_	Confusion	_	_	Hemorrhoids	_	_	Impatience
_	_	Sinusitus	_	_	Decreased Sex Drive	_	_	Fatigue	_	_	Teeth Grinding
_	_	Menstrual Irregularities	_	_	Feel Loss of Control	_	_	Dry Mouth	_	_	Elbow/Hand Pain
_	_	High Blood Pressure	_	_	Excessive Thirst	_	_	Tingling in Hands	_	_	Low Blood Pressure
_	_	Unpleasant Taste	_	_	Clammy Hands	_	_	Sore Muscles	_	_	Neck Pain
_	_	Low Back Pain	_	_	Weak Muscles	_	_	Sore Throat	_	_	Hip Pain
_	_	Lump in Throat	_	_	Knee Pain	_	_	Swallowing Pain	_	_	Poor Circulation
_	_	Unsteady Voice	_	_	Swollen Joints	_	_	Shoulder Pain	_	_	Joint Stiffness
_	_	Persistent Coughing	_	_	Swollen Ankles	_	_	Seizures (Epilepsy)	_	_	Seizures
_	_	Chest Pressure	_	_	Ankle/Foot Pain	_	_	Transplant	_	_	Slow Heart Rate
_	_	Tingling in Feet	_	_	Surgically Implanted Device	_	_	Rapid Heart Rate	_	_	Walking Problems
_	_	Pacemaker									

History of: ___ Cancer: _____ ___ Surgeries: _____ ___Hospitalizations:_____

Miscellaneous & Habits:

Exercise: Light Moderate Heavy Type & Frequency: _____
How many meals/day do you eat?: ____ How much water do you drink?:___
Alcohol Consumption: Light Moderate Heavy None Caffeine: Light Moderate Heavy None
Soda: Light Moderate Heavy None
Work Activity: Heavy Labor Light Labor Mostly Sitting Standing Walking/Moving Driving
How many hours do you sleep at night? ____ Uninterrupted Sleep: Y N Do you feel rested upon waking? Y N

Personal & Family History: Identify conditions that you or any of your family members have now or have previously had. (G= Grandparents, M= Mother, F=Father, S= Siblings, X=Self)

___ Allergies	___ Detached Retina	___ Goiter	___ Mumps	___ Stroke	___ Headaches
___ Alcoholism	___ Diabetes	___ Gout	___ Pleurisy	___ Tumor(s)	___ Migraines
___ Anemia	___ Eczema	___ Heart Disease	___ Pneumonia	___ Ulcer(s)	___ Addiction
___ Cancer	___ Emphysema	___ HIV/AIDS	___ Polio	___ Female Organ Dysfunction	
___ Deep Vein Thrombosis		___ Epilepsy	___ Miscarriage(s)	___ Rheumatic Fever	___ Over weight

Other: _____

Informed Consent to Chiropractic, Acupuncture, and Massage Care

Chiropractic Adjustment: The doctor will use his/her hands or mechanical device in order to adjust your spinal joints. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a "click" or a "pop" as well as a movement of the joint. Various ancillary procedures, such as support pillows, cold laser, traction or hot/cold packs may also be used**. Risks**: As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves, or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days of treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.

Acupuncture: The provider will use procedures including, but not limited to, acupuncture, moxabustion, cupping, electro acupuncture, herbology, and modes of physiotherapy. **Risks**: include, but are not limited to, slight bruising, tingling near the needling sites that may last a few days, nausea, infection and blisters. There have been reported instances of fainting, scarring, spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy.

Massage: The provider will perform soft tissue or muscle work using his/her hands. **Risks:** may include weakness, muscle and joint soreness, ligament strain, muscular strain.

Probability of Risks: The risks and complications of chiropractic care, acupuncture, and massage therapy have all been describes as "rare". The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered as "rare".

Other treatment options which could be considered may include:

- *Over the counter analgesics* which may cause irritation of the stomach, liver, and kidneys, and other side effects in 1,000 to 4,000 people per 1,000,000, and reportedly 16,500 die annually from their use.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these include a multitude of undesirable side effects, and patient dependence in a high number of cases.
- *Hospitalization and bed rest,* in conjunction with medical care adds risks of exposure to virulent communicable disease, loss of muscle tone and strength at the rate of 4% per day.
- *Surgery*, in conjunction with medical care adds the risk of infections, adverse reaction to anesthesia, disfiguring scars as well as an extended convalescent period in a significant number of cases. Serious neurological complication from neck surgery are 15,600 per million, mortality rates are 6,900 per million.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduced skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Office Policies

It is our policy to collect all co-payments and deductibles up to the time of service. If and when your insurance company has determined any additional portion of the bill is due from you, we will send you a statement for the remaining portion that is not covered by your insurance, which is due upon receipt.

Cancelled Appointments: We prefer a **24-hour notice** for your appointment with the doctor. $35 Cancellation Fee. If it's a no show and no call, it will be $35 no show fee after the first occurrence.

Notice of Privacy Practices

Please read the attached information on Privacy Practices.

A copy will be provided at your request

I have had the following risks of my case explained to me. If you/and/or the individual listed below understand the above information, please sign below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and also authorization to submit to insurances (if applicable). Patient or guardian understands that he/she is responsible for payment of all services.

I have read or have had read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing and hereby give my full consent to the items mentioned above.

I have read and understood the Office Policies and acknowledge that if I would like a copy of the Privacy Practices, one will be provided to me.

_____ _____ _____

Printed/Guardian Printed Name Signature Date