Healing Hands Center
FOR INTEGRATIVE MEDICINE
Wayne R. Brown, DC, DAAPM, CFMP

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ____/____/____
Birth Date: ____/____/____ Age: _____ Gender: F M U Decline

If you are under 18 years of age, who are your legal parents or guardian?
Father/Mother/ Guardian: _____
Date of Birth: ____/____/____ Phone: (_____) _____

Marital Status: □ Married □ Separated □ Widowed □ Single How many children? _____
Current address Street_____
City _____State _____ Zip _____
Phone (_____) _____

Your Occupation _____Employer _____
Work Address_____
Work Phone (_____) _____

Name of Spouse _____Spouse's Date of Birth ____/____/____
Spouse's Occupation _____ Spouse's Employer _____
Spouse's Phone (_____) _____

Who should we contact in the event of an emergency? _____
Relationship of emergency contact to patient: _____ Phone (_____) _____

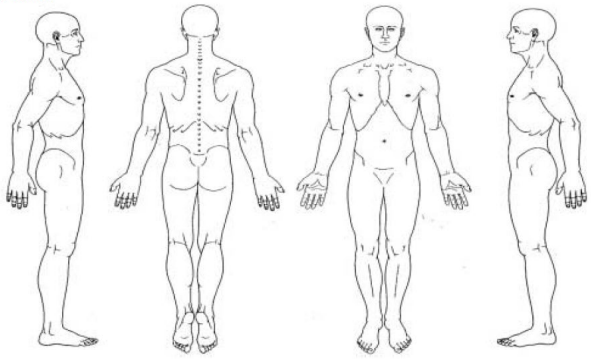
How did you learn about us? _____

Is your condition or injury due to a motor vehicle or work-related accident? □ YES □ NO
Date of accident: ____/____/____

Approximately, when did your injury or condition occur? ____/____/_____

Describe your condition, symptoms, or the purpose of this appointment:
#1_____
#2_____
#3_____

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



[Type here]

Complaint #1: Describe your pain:

☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Radiating ☐ Burning ☐ Throbbing ☐ Numbness
What caused it? _____
What aggravates it? _____
What relieves it? _____
Please rate the severity of your pain (0 = no pain and 10 = extreme pain) 0 1 2 3 4 5 6 7 8 9 10

Complaint #2: Describe your pain:

☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Radiating ☐ Burning ☐ Throbbing ☐ Numbness
What caused it? _____
What aggravates it? _____
What relieves it? _____
Please rate the severity of your pain (0 = no pain and 10 = extreme pain) 0 1 2 3 4 5 6 7 8 9 10

Complaint #3: Describe your pain:

☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Radiating ☐ Burning ☐ Throbbing ☐ Numbness
What caused it? _____
What aggravates it? _____
What relieves it? _____
Please rate the severity of your pain (0 = no pain and 10 = extreme pain) 0 1 2 3 4 5 6 7 8 9 10

Have you ever had the same or similar condition(s)? □ YES □ NO
If yes, when and describe: _____
_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Date of Last Visit: ____/____/_____
Name: _____ Date of Last Visit: ____/____/_____
Name: _____ Date of Last Visit: ____/____/_____

Please list any diagnostic tests you have had in the last two years _____
_____
_____
If you have had any surgery or hospitalization, please describe _____
_____
_____
Have you been treated for any health condition by a physician in the last year? □ YES □ NO
Describe: _____

What medications or drugs are you taking? _____
_____
_____

CONDITIONS

Do you now have, or have you ever had? Please check all that apply.

ALLERGIC-IMMUNOLOGIC: ☐ Hives/Eczema ☐Hay fever ☐ Catch colds easily ☐ Frequent sinus trouble
☐ Frequent influenza ☐ HIV ☐ AIDS ☐ Allergies ☐ Fever

CARDIOVASCULAR: ☐ Murmur ☐ Chest pain ☐ Palpitations ☐ Dizziness ☐ Shortness of breath
☐ Swollen ankles ☐ Heart attack ☐ Irregular heartbeat ☐ Pressure over the chest ☐ Pain down the left arm
☐ High triglycerides ☐ High cholesterol levels ☐ Profuse sweating ☐ Nausea ☐ Vomiting ☐ Low blood pressure
☐ Fainting spells ☐ High blood pressure ☐ Difficulty lying flat ☐ Cardiac Implantable Device (eg. Pacemaker, ICD etc)

CONSTITUTIONAL: ☐ Weight loss ☐ Fatigue ☐ Fever

EAR/NOSE/THROAT: ☐ Difficulty hearing ☐ Buzzing in ears ☐ Ringing in ears ☐ Vertigo ☐ Sinus trouble ☐ Nasal stuffiness ☐ Hearing loss ☐ Ear pain ☐ Mouth sores ☐ Hoarseness ☐ Nose bleeds ☐ Dental problem ☐ Frequent sore throat ☐ Difficulty swallowing

ENDOCRINE: ☐ Loss of hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Goiter

EYES: ☐ Glasses/Contacts ☐ Eye pain ☐ Light bothers eyes ☐ Double vision ☐ Cataracts ☐ Vision problems ☐ Blurred vision ☐ Glaucoma

GASTROINTESTINAL: ☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in BMs ☐ Diarrhea ☐ Black or bloody BM ☐ Gallbladder problem ☐ Liver problem ☐ Hepatitis ☐ Distress from greasy food ☐ Ulcers ☐ Heartburn ☐ Hiatal hernia ☐ Colitis ☐ Blood in the stool ☐ Colon cancer ☐ Abdominal pain ☐ Burning in stomach ☐ Pancreatitis ☐ Jaundice ☐ Pain over stomach ☐ Mucus in stool

GENITOURINARY: ☐ Burning/Frequency ☐ Blood in urine ☐ Erectile dysfunction ☐ Abnormal discharge ☐ Leakage ☐ Incontinence ☐ Kidney infection ☐ Sexual difficulty ☐ Kidney stones ☐ Loss of libido

HEMATOLOGY/LYMPH: ☐ Easy bruising ☐ Gums bleed easily ☐ Enlarged glands ☐ Anemia ☐ Bleeding disorder ☐ Sickle cell anemia ☐ Lymphoma

MUSCULOSKELETAL: ☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle pain ☐ Neck pain ☐ Stiff neck ☐ Back pain ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Bone spurs ☐ Broken bones ☐ Compression fracture ☐ Head injury ☐ Back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defects ☐ Cancer ☐ Muscle weakness ☐ Muscular dystrophy ☐ Scheuerman's disease ☐ Scoliosis ☐ Lupus ☐ Spina bifida ☐ Spondylolisthesis ☐ Arthritis ☐ Neck injury ☐ Osteoporosis ☐ Spinal Cord Stimulator

NEUROLOGICAL: ☐ Loss of strength ☐ Numbness ☐ Headaches ☐ Heavy head ☐ Tremors ☐ Memory loss ☐ Difficulty speaking ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Fainting ☐ Concussion ☐ Migraines ☐ Disorientation ☐ Loss of coordination ☐ Difficulty in walking ☐ Stroke ☐ Alzheimer's disease ☐ Weakness ☐ Disk problem ☐ Light Headed/Dizzy ☐ Epilepsy/Seizure ☐ Tingling

PSYCHIATRIC: ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Difficult sleeping ☐ Nervousness ☐ Tension

RESPIRATORY: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Chills ☐ Chronic cough ☐ Pneumonia ☐ Asthma ☐ Superficial breathing ☐ Chest pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema ☐ Difficulty breathing ☐ Lung cancer

SKIN: ☐ Rash/Sores ☐ Lesions ☐ Itching/Burning ☐ Skin problem ☐ Slow healing ☐ Bruise easily ☐ Psoriasis ☐ Change in moles ☐ Change in skin color ☐ Skin cancer ☐ Scars ☐ Discolorations

MEN'S HEALTH ISSUES: ☐ Burning on urination ☐ Difficulty in starting urine ☐ Dripping urination ☐ Prostate trouble ☐ Prostate cancer

WOMEN'S HEALTH ISSUES: ☐ Hot flashes ☐ Vaginal discharge ☐ Nipple discharge ☐ Menstrual cramps ☐ Premenstrual depression ☐ Lumps in breast ☐ Hysterectomy
The date of last mammogram test was ___/___/_____ ☐ Mammogram is normal ☐ Mammogram is abnormal
The date of last pap test was ___/___/_____ ☐ Pap is normal ☐ Pap is abnormal
The age of onset for periods was ___ ☐ Periods are regular ☐ Periods are irregular
The age of onset for menopause was ___ Number of pregnancies ___

GENERAL: ☐ Recent weight gain ☐ Loss of sleep ☐ Recent weight loss ☐ Loss of appetite ☐ Fatigue ☐ Polio ☐ Rheumatic fever ☐ Cancer of any kind ☐ Metal Rods ☐ Pins ☐ Screws ☐ Staples ☐ Any Metal Beneath Skin

OTHER: _____
_____
_____
_____

FAMILY HEALTH HISTORY:

Father: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Other ☐ Seizure ☐ Stroke/TIA ☐ Tuberculosis ☐ Ulcer

Mother: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Other ☐ Seizure ☐ Stroke/TIA ☐ Tuberculosis ☐ Ulcer

Brother: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Other ☐ Seizure ☐ Stroke/TIA ☐ Tuberculosis ☐ Ulcer

Sister: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Other ☐ Seizure ☐ Stroke/TIA ☐ Tuberculosis ☐ Ulcer

Son: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Other ☐ Seizure ☐ Stroke/TIA ☐ Tuberculosis ☐ Ulcer

Daughter: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Kidney Disease ☐ Liver Disease ☐ Other ☐ Seizure ☐ Stroke/TIA ☐ Tuberculosis ☐ Ulcer

INSURANCE and PAYMENT POLICY DETAILS

Do you have health insurance? □ YES □ NO
Company: _____
Full Name of Policy Holder: _____Policy Holder's Date of Birth ____/____/_____
Health insurance ID: _____ Group number: _____
Does the policy holder have the insurance through his/her employer? □ YES □ NO
If yes, who is the employer? _____

I understand that I am required to pay for services at the time of my office visit. If it is determined that my insurance company will reimburse me for services I have received from Dr. Brown, the office staff will submit a completed claim to my insurance company on my behalf. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me.

I have been advised that Dr. Brown and/or his staff will not enter into any dispute with my insurance company. I further understand that any reimbursement from my insurance company is solely based on their contractual relationship with me.

In an effort to efficiently process my billing, I have decided to place a credit card on file with Dr. Brown's office to pay for my services.

_____ _____
Visa/MasterCard/AMEX number Exp. Date

_____ _____
Name on the card Security Code

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____
Date: ____/____/_____