

**HANCOCK HOLISTIC CLINIC
DEPENDENT PATIENT HISTORY FORM**

Information you provide here is privileged and confidential. Your privacy will be respected.

Date: _____
Dependent's Name: _____ Middle Initial: _____ Last Name: _____
Address: _____
City/State/Zip: _____
Sex: _____ Age: _____ Birthdate: ____/____/____ Height: _____ Weight: _____

Parent / Guardian Information

Name _____ Relationship to dependent: _____
Phones - Home: _____ Work: _____ Cell: _____
Occupation: _____ Marital Status: _____ Children: _____
Employer: _____ Work site – City / State: _____
Name of Spouse or Significant Other: _____
Their Employer: _____ Work site – City / State: _____
How did you learn about our clinic? _____
General health: _____

Which of the following "Complementary" health care therapies has dependent utilized? (please circle)

Massage/Bodywork Chiropractic Nutritional Acupuncture Homeopathic Naturopathic

Other: _____

Describe the health care reason for which the dependent came to see us: _____

When did this start and/or how did this develop? _____

Other Professionals seen for this problem: _____

Diagnosis, if known, and current treatment: _____

Describe the results from previous treatments for this condition: _____

Activities/tasks/movements which the dependent is unable to perform, or which cause or increase problems: _____

School or work dependent missed due to the presenting problem noted above: _____

List ALL surgeries (with year they occurred): _____

_____ (cont. on back of page if necessary)

Is the dependent currently under a physician's care? Yes No If yes, please explain: _____

Name of Dependent: _____ Date: _____

FALLS, AUTO ACCIDENTS & OTHER TRAUMAS

DATE OF TRAUMA: _____ **DESCRIBE EVENT:** _____

DESCRIBE DEPENDENT'S INJURIES: _____

MEDICAL TREATMENT RECEIVED: _____

CURRENT SYMPTOMS ASSOCIATED WITH THIS TRAUMA: _____

DATE OF TRAUMA: _____ **DESCRIBE EVENT:** _____

DESCRIBE DEPENDENT'S INJURIES: _____

MEDICAL TREATMENT RECEIVED: _____

CURRENT SYMPTOMS ASSOCIATED WITH THIS TRAUMA: _____

DATE OF TRAUMA: _____ **DESCRIBE EVENT:** _____

DESCRIBE DEPENDENT'S INJURIES: _____

MEDICAL TREATMENT RECEIVED: _____

CURRENT SYMPTOMS ASSOCIATED WITH THIS TRAUMA: _____

Name of Dependent: _____ Date: _____

Describe any skin disorders: _____

List any known sensitivities or allergies: _____

Does the dependent have ANY OTHER medical condition or physical limitation that we as health care providers may need to be aware of before he/she receives therapy? (please explain):

Are there any known emotional issues relating to bodywork or touch? Yes Uncertain No

Current prescriptions, vitamins, minerals and over-the-counter medications: _____

Does Dependent

Regularly drink caffeinated beverages? (sodas or energy drinks / tea / coffee) No Yes
How much? _____

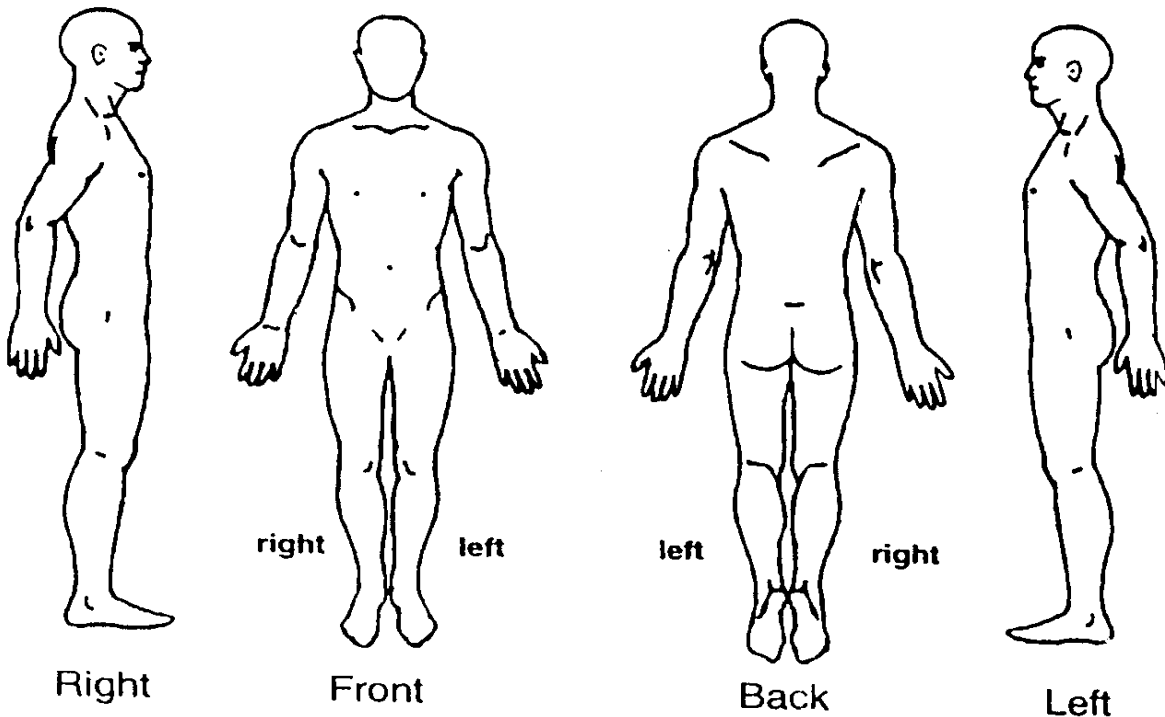
Regularly drink "diet" beverages or use artificial sweeteners? _____ How much? _____

Drink alcoholic beverages? No Yes _____ Use tobacco? No Yes _____

Does dependent engage in sports / physical-fitness type activity on a regular basis? Yes No

If any, please describe: _____

Please **shade in** clearly **ALL areas** where dependent has frequent or occasional pain or problem:



Name of Dependent: _____

Date: _____

Please check all of the following that now apply or have applied to you:

System-wide:

- Broken bones
- Cancer
- Diabetes
- Fatigue
- Sleep problems
- Food / Diet / Eating Concerns
- Weight concerns thin / heavy

Allergies/Sensitivities:

- Medications
- Foods/additives
- Chemicals/fragrances

Back/Buttocks/Hips/Pelvis:

- Spinal deformity / damage
- Lower back pain
- Mid back pain
- Upper back pain
- Hip pain
- Coccyx (tail-bone) pain

Balance/Ears/Eyes:

- Dizziness
- Falls/loss of balance
- 'Accident-prone'
- Ear infections – frequent
- Ear-aches
- Tubes in ears
- Ears 'ring', 'hum', throb
- Hearing Concerns
- Hearing aid
- Eye pain
- Glasses or Contacts
- Eye surgeries
- Other vision Concerns

Circulation/Blood/Veins:

- Anemia (low iron)
- Blood sugar -- High Low
- Fainting
- Heart abnormality

Chest/Breathing/Ribs:

- Asthma
- Pain with deep breath

Development Concerns:

- PDD (Developmental Disorder)
- Sexual Development concerns
- Urinary / Bowel Control
- Females – Menstrual Problems

Emotional & Relationships:

- Anger/Hostility issues
- Clingy
- Withdrawn or Depression
- Significant irritability
- 'Mood swings'
- Issues with being touched
- Peer Relationship Concerns
- Family Relationship Concerns

Head/Brain/Neck/Throat:

- Headaches
- Brain feels 'in a fog' - thinking Is 'fuzzy' or 'poorly connected'
- Neck pain
- 'Stiff neck' or restricted movement
- Sinusitis
- Other nasal problems
- Seizures
- Scalp pain and/or scalp problems
- Throat / Voice problems or pain
- Whiplash

Internal Organs:

- Constipation
- Diarrhea
- Intestinal problems
- Stomach problems
- Other internal problems
- GERD (Acid Reflux)

Lower Limbs - Legs/Knees/Ankles/Feet:

- Knee pain
- Leg pain
- Feet hurt
- Feet cold
- Feet numb or 'tingle-y'
- Sciatica

Oral/TMJ:

- TMJ problems
- Teeth or bite problems
- Orthodontics (Braces)
- Mouth/jaw pain
- 'Clicking' / 'Popping' in jaws

Posture:

- Scoliosis
- 'Stoop-shouldered'
- 'Bad posture'

Skin:

- Rashes
- Unexplained redness
- Skin diseases, etc.
- Fungus infections
- Skin Problems / Acne

Upper Limbs - Shoulders/Arms/Wrists/Hands

- Shoulder pain
- Elbow pain
- Wrist pain
- Hands cold
- Hands hurt
- Hands numb or 'tingle-y'

Name of Dependent: _____ **Date:** _____

Birthdate: ____/____/____

I have listed all of this dependent's known medical conditions and physical limitations, and I will inform this provider of any changes in his / her physical health. I understand that a licensed health care provider who is treating this dependent's must be aware of all existing physical conditions that exist in order to provide appropriate and informed care.

I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

Signature

Date

Name (please print)

I understand the information contained herein is privileged and confidential, and at this time I authorize the release of any information pertaining to this dependent's health to his/her attorney, insurance company, and/or referring physician(s) or therapist(s). Furthermore, I authorize the above persons to release any pertinent information about him/her if needed, to this provider. I understand that this information will be treated as privileged and confidential.

Signature

Date

Name (please print)

Name of Dependent: _____ Date: _____

Birthdate: ____/____/_____

As responsible health care providers, the following health-related factors are important for us to know so we can provide this dependent with the most appropriate and most effective care. Some of these factors also affect the precautions that our clinic must take to minimize the risks of spreading contagious conditions. In accordance with current laws and HIPAA, these healthcare concerns are considered **HIGHEST CONFIDENTIALITY TOPICS**.

Therefore, this page is NOT released to other health care providers, insurers, OR any other entity except by court order. Thank you for your trust.

- Drug Abuse
 - Alcohol (please check: ___ past ___ present ___suspected)
 - Street Drugs (please check: ___ past ___ present ___suspected)
Which drugs? _____
 - Prescription Abuse (please check: ___ past ___ present ___ suspected)
Which drugs? _____

- Abuse Survivor
 - Physical (please check: ___ past ___ present ___suspected)
 - Emotional (please check: ___ past ___ present ___suspected)

- Contagious Diseases
 - AIDS
 - HIV
 - STD(s) _____ (please check: ___ past ___ present ___unknown)
 - Hepatitis - Type _____ (please check: ___ past ___ present)
 - _____
 - _____

Dependent's Name

Signature of Parent or Guardian

Date

Name (please print) of Signature of Parent or Guardian