Dr. Samuel G. Hammel
173 E. Chicago Street, Coldwater, Michigan 49036

Confidential Patient Health Record

Name _____ Marital Status (circle one) M S W D

Address _____ City _____ Date of Birth: _____ Age:_____

State _____ Zip _____ How many children? _____ Home Phone _____

Social Security # _____ - _____ - _____ Work Phone _____

Occupation _____ Employer _____

If Insured, Name of Company _____

Name of Spouse _____Spouse Birthday _____ Spouse Ins. Co. _____

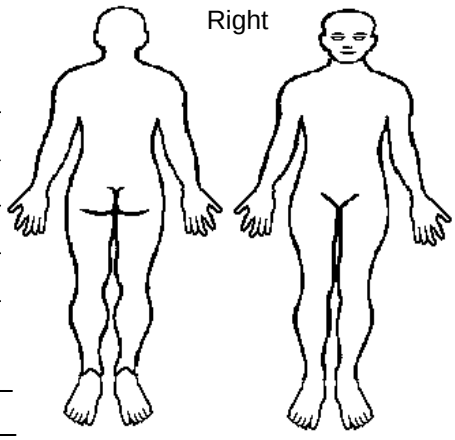
If You are a Minor, Parent's Insurance Co._____ Parent's Birthdate_____

Referred By:_____

Present Family Doctor _____ Date of Last Physical Exam _____

Was This the Result of an Injury at :
☐ Auto ☐ Work ☐ Other **DATE OF INJURY:**_____

MARK AREA OF COMPLAINT



Describe injury or complaint and what you think caused it:

_____

_____

_____

_____

_____

List other doctors consulted for this condition(s):

Doctor's Name: When consulted?

Diagnosis: Treatment:

List serious accidents, falls or broken bones: _____

_____ When?_____

Where you ever knocked unconscious? ☐Yes ☐No

Explain: _____

Circle the number that best describes the level of your pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain

Habits

Have you ever smoked?_____Yes _____ No

Smoking _____ packs / day _____ years

Coffee _____ cups per day

Sleep _____ hours per night

Exercise _____ times per week

Family History

please (**X**) appropriate box

		Diabetes	Heart	Kidney	Cancer	Back
Father		☐	☐	☐	☐	☐
Mother		☐	☐	☐	☐	☐
Brother	No. of _____	☐	☐	☐	☐	☐
Sister	No. of _____	☐	☐	☐	☐	☐

Please list the medications and vitamins or food supplements you are taking:
(including prescription drugs, birth control, and over the counter drugs like aspirin, cough syrup, etc.)

1. For: Approximately how long?
2. For: Approximately how long?
3. For: Approximately how long?
4. For: Approximately how long?
5. For: Approximately how long?

List Allergies: (medicine, dust, ragweed, certain foods)

1. 2.

3. 4.

Check* (X) *any of the following illnesses of diseases you have or have had:

☐ Diabetes	☐ Chicken pox	☐ High cholesterol	☐ Arthritis
☐ Cancer	☐ Polio	☐ Tuberculosis	☐ Influenza
☐ Heart attack	☐ Appendicitis	☐ Rheumatoid arthritis	☐ Whooping cough
☐ Stroke	☐ Chronic cough	☐ Anemia	☐ Epilepsy
☐ Kidney stones	☐ Measles	☐ Goiter	☐ Pleurisy
☐ Prostate problem	☐ Mumps	☐ Osteoporosis	☐ Pneumonia

NECK, BACK, EXTREMITY *Check* (X) *conditions you presently have or have had in the <u>past year</u>*

Neck & Shoulders
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Grinding/poping sounds in neck

Mid-Back
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Mid-back stiffness

Arms & Hands
- ☐ Pain down arm
- ☐ Pain/numbness in hand

Hips, Legs & Feet
- ☐ Pain in buttocks
- ☐ Pain/numbness down leg

Low-Back ☐ Low back pain ☐ Low back stiffness

GENERAL SYMPTOMS *Check* (X) *conditions you presently have or have had in the <u>past year</u>.*

General
- ☐ Fever
- ☐ Headache
- ☐ Migraine headaches
- ☐ Loss of weight
- ☐ Weight gain

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Blood in stool

Eye, Ear, Nose, Throat
- ☐ Blurred vision
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Dizziness

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Difficulty starting and/ or stopping urine

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

Women Only
- ☐ Menstrual pain
- ☐ Abnormal bleeding

Are you pregnant? ☐ Yes ☐ No ☐ not sure

☐ Menopause When? _____

Please list the surgeries and hospitalizations that you have had and their approximate dates:

1.	Date:	Doctor:
2.	Date:	Doctor:
3.	Date:	Doctor:
4.	Date:	Doctor:

List past illnesses: (heart attack, thyroid, kidney etc.)

1.	Date:
2.	Date:

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and yourself and that YOU are personally responsible for payment of any and all services covered or not covered (which includes deductibles and copays). I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

I (we) authorize the doctor/therapist and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, healthcare provider or attorney in order to prove any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorized and direct payment of any medical/chiropractic expense benefits allowable to the doctor/therapist as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo copy of this agreement shall serve as the original.

_____ _____

Patient Signature **Date**

_____ _____

Guardian or Spouse's Signature Authorizing Care **Date**