

# HEALING HANDS CHIROPRACTIC

1445 Rio Road E., Suite 201, 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: \_\_\_\_\_  
 # Dependents: \_\_\_\_\_  
 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

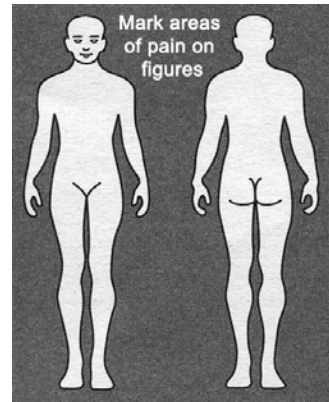
What treatment have you already received for this condition?  Medications  Surgery  Physical Therapy

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:**

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

PLEASE INDICATE IF <i>YOU</i> 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		
Heart Disease		
Hepatitis		
Hernia		
Herniated Disk		
Herpes		
High Blood Pressure		
High Cholesterol		
Kidney Disease		

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:	YES	NO
Liver Disease		
Measles		
Migraine Headaches		
Miscarriage		
Mononucleosis		
Multiple Sclerosis		
Mumps		
Osteoporosis		
Pacemaker		
Parkinson's Disease		
Pinched Nerve		
Pneumonia		
Polio		
Prostate 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:**

