Special Instructions for Filling Out Forms:

1) Please fill out completely. We need this to fulfill documentation requirements and to accurately assess your health and condition.
2) Anything that does not apply, draw a line through it.
3) If you need help, ask the receptionist. Call us if we have faxed or emailed and you need help.
4) Please bring to the front desk when finished. If we faxed or emailed, bring filled-out forms to your appointment.

Mark Hogue, D.C./Hogue Chiropractic
Matavia Johnson, Wellness Advocate
The Road to Health and Wholeness
142 North Gamble Street Shelby, Ohio 44875
419-342-2931(phone)~~419-347-7096(fax)

Confidential Patient Information Date:

Patient Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
City: _____State_____ Zip:_____ Cell Phone: _____
SS#: _____ Email: _____
Date of Birth: _____ Marital Status: M S W D Children names and ages:
Occupation: _____ Employer: _____
How did you find out about our office?_____Pets:

Person to contact in case of emergency (Name and Phone): _____
Have you ever been under Chiropractic Care? Y N If so, with whom?_____Nutrition care? Y N_____
Have you had any X-rays / MRI / CT taken in the last year? Y N If so, where? _____
What serious accidents or injuries have you had?:_____
What operations have you had? _____ When? _____
_____
Serious Medical Condition_____ When? _____
_____
Infectious Diseases: _____ When? _____
_____
Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**
What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart attack/stroke	Y N Heart surgery	Y N Heart Murmur	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Sleep problems
Y N Hepatitis	Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent neck pain	Y N Emphysema	Y N Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic fever	Y N Headaches
Y N Kidney problems	Y N Ulcers/Colitis	Y N Sinus problems	Y N Fainting\
Y N Arthritis	Y N Artificial bones/joints	Y N Lower back problems	Seizure\
Y N Chemotherapy/Radiation	Y N Difficulty Breathing	Y N Tuberculosis	Epilepsy
Y N Asthma	Y N Diabetes	Y N Sexually Transmitted Disease	Y N Difficulty Breathing

Who is your medical physician?_____

Chief Concerns: 1)_____How long?____
2)_____How long?___
3)_____How long?___

Confidential Patient Information and Case History Continued Name_____Date___/___/___

Please list anything that you are allergic to :_____
_____
List any past serious accidents or falls with dates:_____
_____
Family Health History:_____
_____
Do You: Take supplements or Vitamins? ◯Yes ◯No / Exercise? ◯Yes ◯No/ Are you on a special diet? ◯Yes ◯No Since:__/__/__
Do you smoke? ◯No ◯Yes/ How much? _____How long?_____
Are you wearing: ◯Heel lifts ◯Sole lifts ◯Inner soles ◯Arch supports Do you wear your seatbelt? ◯Yes◯No
What is the age of your mattress?_____Is it comfortable? ◯Yes ◯No

For Women: Are you taking birth control? ◯Yes ◯No Are you pregnant? ◯Yes /How long?_____ ◯No Nursing? ◯Yes◯No

Review of Systems**(Leave this section blank. The doctor will review this with you):**

1) Constitutional: Vital signs: 1) sitting or standing blood pressure____, 2) supine blood pressure____, 3) pulse rate and Regularity____4) respiration____, 5) temperature____, 6) height____, 7) weight____

2) Head, Face, neck

3) Eyes, ears, nose, mouth, throat
Teeth missing:
Teeth with fillings and type:

4) Nervous/psychiatric

5) Endocrine:

6) Cardiovascular:

7) Lymphatic:

8) Respiratory:

9) Gastrointestinal:

10) Urinary/ Reproductive:

11) Integementary(skin):

12) Musculoskeletal:

SUBSTANCE SURVEY FORM

NAME:_____ **DATE:**_____

Please list any prescription medications you are currently taking or have taken in the last year.

Medications	**Diagnosis**

Please list any over-the-counter medications you are currently taking or have taken in the past year.

Product	**Symptom**	**Quantity & Frequency Taken**

Please list any vitamins, supplements, herbs or homeopathic medicines you are currently taking or have taken in the past year. (use other side of paper if needed)

Product	**Amount Taken Daily**	**How Long Taken**

Check the following items which apply to you and indicate the amount used:

- ◯ COFFEE _____
- ◯ TEA _____
- ◯ SOFT DRINKS _____
- ◯ ARTIFICIAL SWEETNERS _____
- ◯ ANTACIDS _____
- ◯ LAXATIVES _____
- ◯ CANDY _____
- ◯ ICE CREAM _____
- ◯ ALCOHOL _____
- ◯ CIGARETTES _____
- ◯ OTHER TOBACCO PRODUCTS _____

How many desserts do you have in an Average week? _____

Other information:_____

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY SYSTEMS

Patient Name:_____ **Date Today:**_____

HEADACHES
__Base of Skull (Back)
__Side of Head (Temples)
__Frontal (Above Eyes)
__Top of Head
__Entire Head
__Migraines
__Cluster
__Other_____

EARS
__Noise (Ring/Hiss/Pound)
__Plugged
__Popping
__Ear Ache
__Draining
__Itching
—Hearing Loss
__Dizziness/Vertigo
__Excessive Earwax
__Other_____

EYES
—Burn
__Tear
__Ache
__Red
__Dry
__Eye Film
__Crust in Morning
__Itchy Eyes
__Bouts of Blurriness
__Floaters
__Spots
__Tired
__Puffy
__Styes
__Twitching Around Eyes
__Dark Circles
__Light Bothers Eyes
__Nearsighted
__Farsighted
__Other_____

SINUS
__Nose Bleeds
__Dry
__Drain
__Stuffy/Plugged Up
__Sneeze Frequently
__Smell Loss
__Taste Loss
__Post Nasal Drip: (circle color)
WHITE/YELLOW/GREEN
GREY/BROWN/BLOODY/
CLEAR
__Other_____

MOUTH/THROAT/ IMMUNE
__Blisters
__Canker Sores
__Bad Breath
__Bleeding Gums
__Receding Gums
__Teeth Health Problems
__Dry Mouth
__Swelling of Glands
__Difficulty Swallowing
__Sore Throat
__Hoarseness
__Fever
__Chills
__Cold/Sweaty hands or feet
__Cough (dry or productive?)
__Environmental Allergies
__Upper Respiratory Infection
__Frequent Colds/Flu
__Chronic Bronchitis
__Other_____

CHEST
__Tension
__Tight
__Pressure
__Heaviness
__Congestion
__Chest Pain
__Sternal Pain
__Sharp Heart Pain
__Palpitations-Heart Skip/Flutter
__Heart racing
__Heart Slow Down
__Mitral Valve Prolapse
__Murmur
__Other_____

SHORTNESS OF BREATH
__Constant
__Upon Exertion
__Wheeze
__Air Hunger
__Asthma
__Frequent Sighs
__Emphysema
__Other_____

STOMACH
__Heartburn
__Indigestion
__Stomach Aches
__Stomach Cramps
__Nausea/Queasy
__Bloat after Eating
__Gas/Flatulence
__Belching
__Ulcer
__Hiatal Hernia
__Other_____

BOWELS
__How many Bowel Movements/Day
__Regular
__Incomplete
__Skip days____per (week/month)
__Sluggish bowels every ____ days
__Cramps in Abdomen
__Taking Laxatives
__Using Suppositories
__Enemas
__Colonics
__Bulky
__Pan with Bowel Movements
__Irritable Bowel Syndrome
__Chrons
__Colitis
__Other_____

FECAL CONSISTENCY
Color of Feces-LIGHT or DARK
__Normal
__Soft
__Hard
__Pebbles
__Dry
__Ribbon-Like
__Mucous
__Diarrhea
__Constipation
__Other_____

HEMORRHOIDS
__Swollen
__Burning
__Blood
__Distended
__Itchy
__Stingy
__Achy

URINATION
__Times per Day (frequency)
__Urinate at Night__ X Per Night?
__Urgency
__Burning
__Pain
__Order
__Spasm
__Leakage
__Urinary Tract Infection
__Incontinence
__Kidney Troubles
__Other_____

ENERGY
__Low
__Variable
__Normal
__High
__Slow to Start in the Morning
__Low Energy After Meals
__Energy Crash __AM __PM
__Other_____

SLEEP
__Quality (poor/fair/good/great)
__Hours in Bed
__Hours Asleep
__Difficulty Falling Asleep
__Difficulty Staying Asleep
__Interrupted __X per Night?
__Crave Sleep During Day
__Awaken Suddenly (jolt)
__Don't Remember Dreams
__Nightmares
__Night Sweats
__Restlessness
__Sleep Apnea
__Other_____

EMOTIONS
__Stressed
__Sad
__Grief
__Depression
__Moodiness
__Frustrated
__Irritable
__Angry
__Worrisome
__Nervous
__Anxiety
__Panic
__Cry
__Fear
__Shame
__Other_____

APPETITE/DIET
__Low Appetite
__Normal Appetite
__High Appetite
__Starch (pasta/bread/potatoes/rice)
__Sweets
__Chocolate
__Coffee __cup/day
__Caffeinated Tea __cups/day
__Beer __per week
__Wine __per week
__Juice __per week
__Soda __per week
__Artificial Sweeteners
__Eat a lot of Spicy Foods
__Ice Cream

EXERCISE
__Cardiovascular __X per week
__Weight Training __X per week

MEMORY
__Forget Names
__Forget Numbers
__Forget Words
__Forget Actions
__Difficulty Concentrating
__Other_____

LIBIDO/SEXUALITY
__Flat
__Low
__Normal
__Erectile Dysfunction (men)
__Orgasm Quality (poor/fair/good)
__Other_____

SKIN/HAIR/NAILS
__Skin Rash
__Acne
__Dry Skin
__Itchy Skin
__Patches: skin looks different
__Cellulite
__Nails
__Hair Loss
__Limp hair
__Other_____

CRAMPS/ACHES/ RESTLESS
__Cramps (legs/feet/arms/hands)
__Aches (legs/feet/arms/hands)
__Restless (legs/feet/arms/hands)
__Other_____

PAIN/STIFFNESS/ SWELLING/ NUMBNESS/ TINGLING
__Facial
__Neck
__Trapezeus
__Upper back
__Shoulders
__Arms
__Elbows
__Wrist
__Hand
__Mid Back
__Low back
__Sacral Iliac
__Hips
__Buttocks
__Legs
__Sciatica
__Knees
__Ankles
__Feet
__Other_____

FOR MEN ONLY (PROSTRATE)
__Burn
__Achiness
__Pain
__Restriction
__Dribbling
__Emission
__Swelling
__Other_____

LIST YOUR PRIMARY CONCERNS :
_____
_____
_____

MENSES (women only)
Last Menstrual Period_____
Length of Menses_____
__Regular
__Irregular
__Early (less than 28 days)
__Late (more than 28 days)
__Skip
__Birth Control Pills
__Flow (Heavy/Moderate/Light)
__Clotting/Spotting
__Cramps (Mild/Moderate/Severe)
__Low Abdominal Puffiness
__Fluid Retention Face
__Fluid Retention Hands
__Fluid Retention Feet
__Tired During Cycle
__Acne (Pre/Post)
__Mood Swings/Irritable/Depressed
__Breast Tenderness Near Cycle
__Other_____

BREASTS (women only)
__Breast Tender Constant
__Breast Feeding
__Fibrosis
__Lump
__Discharge
__Prosthesis
__Augmentation
__Reduction Surgery
__Pathology
__Other_____

VAGINA (women only)
__Burn
__Itch
__Dry
__Pain
__Blood
__Discharge
-Clear
-White
-Yellow
-Green
-Brown
-Odor
__Other_____

MENOPAUSE (women only)
__Natural
__Surgical (partial/complete)
__Hormones
__Patch
__Hot Flashes
__Skin Crawling
__cherry Hemanglomas
__Facial hair
__Hair Growing Up Toward
Belly Button
__Dark Nipple Hair
__Other_____

FOR DOCTOR'S USE
__Frenular Cyst
__Cracks in Tongue
__Allergy Patches Tongue
__Geographic Tongue
__Red Spots Tongue
__Swollen Tongue
__Color Tongue_____
__Dark Veins Tongue
__Coated Tongue (mild/mod/severe)
__Ear Creases (Rt/Lt)
(mild/moderate/severe)
Weight_____
Height_____
Pulse_____
BP_____
Saliva PH_____
Urine PH_____
Allergies_____
Current
Meds:_____
_____
_____

Mark Hogue, D.C. The Road to Health and Wholeness
142 North Gamble Street Suite B Shelby, Ohio 44875
419-342-2931(phone)◯419-347-7096(fax)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Hogue Chiropractic: The Road to Health and Wholeness
Mark Hogue, D.C. 142 N. Gamble St Shelby, Ohio 44875
419-342-2931(phone)

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **The Ohio State Chiropractic Association**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____