Hamel Chiropractic and Wellness -PATIENT INFORMATION

(Please fill in your information **in detail** so Dr. Hamel 1. Can determine whether he can help you or not and 2. If so give you his best recommendations so you can get the results you are looking for.)

Name:____ Date:________________

Address:____

City/State/Zip:____

Best Email Contact:_________________________________ Cell#_____________________

Sex:___M ___F Height:_______ Weight:_____ Age:_________ Date of birth:________________

Occupation:________________________ Employer:_________________________________

Marital Status:______ Spouse's Name:_________________________ # of Children:__________

Name of Primary Care Doctor/MD____

Who can we thank for referring you in?____

____

If your MD did not refer you, how did you find out about our office?_______________________

____

Where is your pain and/or other symptoms? (check what applies)

__Neck and back Pain/Stiffness __Sciatica __Knee Pain __Bulging/Herniated Discs/Degeneration

__Headaches/Migraines __Hip Pain __Arthritis/Joint Inflammation __Shoulder Pain __Carpal Tunnel

What kind of pain are you having (circle): shooting burning stabbing numbness sharp throbbing

throbbing constant other:________________________

How long have you been dealing with this/these problems? __1 week, __1 month, __1 year, __over 1 year

Since your problem started is it: ___about the same ___getting better ___getting worse

If you become a patient Dr. Hamel will send you an email with specific information about your diagnosis and corrective exercises to help get you better quicker, is this OK: ___Yes ___ No

Impact Of Your Symptoms

How is the symptom/condition interfering with your life?, (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work					Lifting				
Exercise					Sitting				
Relationships					Standing				
Sleep					Walking				
Self Care					Travel				
Energy					Driving				
Hobbies					Other				

Why is it important to fix this problem now?____

____

What have you tried in the past to improve your condition?(Circle): Medicine, PT, Chiro, Massage, Exercises, Cryotherapy, Surgery, Supplements. Did anything help? __________________________

What are your goals for seeking out care in our office for your condition(s)?

___I just want to take pills to feel better
___I would like to correct the underlying problem so it doesn't return
___I want to correct the underlying cause and have a strategy to be pain free long term.

What other health issues do you have that might be contributing to your aches and pains? (Circle) Overweight, Poor Diet, Diabetes, Arthritis, Autoimmune Condition, Stress, Anxiety, Poor Sleep, Fatigue

Would you like to learn corrective exercises to help you feel better quicker and have the treatments be more effective? Yes___ No___

Are you open minded to taking natural supplements to help with pain, inflammation and to help speed up the healing process? Yes____ No____

Is there any other health concerns that you would like Dr. Hamel to address? ____________________

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Notice of Privacy Practices

Acknowledgment Form

We will never share your personal or private information with others.

We may only disclose information about you in the following ways:

- To another health-care provider, hospital or facility if they request it in order to assist them in caring for you.
- To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.
- If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you correspondence by email/text.

My signature acknowledges I have read this notice, understand it and agree with the policies explained.

Name (Print) ____

Signed ____________________________________ Date ____/____/____