# SOUTH ALBANY CHIROPRACTIC CLINIC

2625 QUEEN AVE. S.E.
ALBANY, OREGON 97322
928-8266

**DR. CARL R. HANSON D.C.**

**CONFIDENTIAL PATIENT INFORMATION** DATE: _____

FULL NAME: _____ PHONE: _____ AGE: _____ SEX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ DRIVERS LICENSE#: _____

MARITAL STATUS: M S W D CHILDREN: _____ SPOUSES NAME: _____

EMPLOYER: _____ OCCUPATION: _____ HOW LONG: _____

SPOUSE EMPLOYER: _____ OCCUPATION: _____ HOW LONG: _____

REASON YOU CAME TO THIS OFFICE: _____

WAS IT CAUSED BY FALL: _____ TRAUMA: _____ AUTO ACCIDENT: _____

WORK INJURY: _____ STRAIN: _____ SPORTS: _____

UNKNOWN: _____

DATE STARTED: _____ THIS HAPPENED BEFORE: _____ DATE: _____

DAYS MISSED WORK: _____

PAIN IS: WORSE SITTING: _____ WORSE MOVING: _____ WORSE AT NIGHT: _____

PAIN IS: DEEP ACHE: _____ BURNING SENSATION: _____ SHARP PAIN: _____

ELECTRIC SHOCK: _____ THROBBING: _____ WORSE AT DAY: _____

PRIOR SURGERIES: _____

PRIOR ILLNESSES: _____

CURRENT MEDICATIONS: _____

_____

OTHER DOCTORS: _____

DO YOU HAVE NOW OR PREVIOUSLY HAVE HAD:

| | | | |
|---|---|---|---|
| _____ HEADACHES | ____ NUMBNESS IN FINGERS | ____ DIZZINESS | ____ DIARRHEA |
| _____ NECK STIFFNESS | ____ NUMBNESS IN TOES | ____ FAINTING | ____ CONSTIPATION |
| _____ NECK PAIN | ____ PINS/NEEDLES IN LEGS | ____ LOSS OF MEMORY | ____ URINARY PROBLEMS |
| _____ MID BACK PAIN | ____ PINS/NEEDLES IN ARMS | ____ UNCONSCIOUSNESS | ____ KIDNEY PROBLEMS |
| _____ LOW BACK PAIN | ____ WEAKNESS IN HANDS | ____ LOSS OF BALANCE | ____ STOMACH ULCERS |
| _____ MUSCLE TENSION | ____ WEAKNESS IN LEGS | ____ COLD SWEATS | ____ HIGH BLOOD PRESSURE |
| _____ SLEEPING PROBLEM | ____ LOSS OF FEELING | ____ FEVER | ____ DIABETES |
| _____ MUSCLE CRAMPS | ____ NERVOUSNESS | ____ STROKE | ____ CANCER |
| _____ ARTHRITIS | ____ DIFFICULTY BREATHING | ____ SCIATICA | ____ PG |

EXAMINATION **Office Use Only**

VITALS:

HEIGHT: _____WEIGHT: _____

BP:_____BP:_____

PULSE: _____TEMP: _____RESPIRATION:_____

_____ MEMORY_____ FINGER TO NOSE_____ EYE MOTION

LIGHT REACTION

_____ PROPREIO ____ RHOMBERG _____ FACIAL EXPRESSION/

SENSATION

_____ COUGH/SWALLOW/TONGUE/SHRUG

OBJECTIVE:

1) ROM

2) DTR

MOTOR

SENSORY

3) POSTURE:

4) ORTHO:

5) VASCULAR:

6) X-RAY RECOMMENDED:

OBSERVATION:

OTHER REFERRAL

DIAGNOSIS:

COMPLICATIONS:

NAME:_____ PATIENT #:_____

PHONE #: _____ DATE:_____

ADDRESS: _____

Current History:

Antalgia:

Cause:

Location of pain:

Duration: < >

Past Treatment:

Medication:

Other Doctors:

Past History:

Accidents/falls/auto:

When:

Dr.:

Treatment:

Hospital: Date: _____

Location: _____Problem: _____

Broken bones: when _____ what _____

Dr. _____

Allergies: Medication:
Foods:
Animals:

| | | | |
|---|---|---|---|
| Current: | Diet | Cholesterol | Diabetes |
| | Exercise | Stress test | Heart |
| | Vitamins | EKG | Cancer |
| | Smoking | | |

Hobbies:

Cautions: