DR. TERRESA HWANG
CHIROPRACTOR

PERSONAL INFORMATION

Name Date

Address City State Zip

Cell phone Home phone

Work phone Email

Employer Type of work

Date of birth Age Sex: ○ Male ○ Female

EMERGENCY CONTACT

Name Phone

Relationship

PAYMENT INFORMATION

Who is responsible for your bill? ○ Out of pocket ○ My insurance company ○ My spouse's insurance company ○ Workers' Comp ○ Auto insurance ○ Medicare

Health insurance company Policy number

Name of insured Insured's date of birth

CURRENT HEALTH CONDITION

Reason for visit

Condition is the result of: ○ Job related ○ Auto accident ○ Home injury ○ Sports injury ○ Fall ○ Other (specify)

Accident date/time Have you made an accident report to your employer or insurance? ○ Yes ○ No

Type of pain: ○ Sharp ○ Dull ○ Throbbing ○ Numb ○ Stiff ○ Burning ○ Aching ○ Shooting ○ Tingling ○ Cramping

Severity of pain: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

When and how did this condition begin?

Has the condition occurred before? ○ Yes ○ No Is the condition getting worse? ○ Yes ○ No

How often do you have this condition? Does it interfere with: ○ Work ○ Sleep ○ Daily routine ○ Recreation

Painful activities: ○ Sitting ○ Standing ○ Lifting ○ Walking ○ Lying down ○ Other (specify)

Have you seen another physician for this condition? ○ Yes ○ No If so, who?

Previous treatment(s)

Results of previous treatment(s)

Current medications: ○ Nerve pills ○ Pain killers/muscle relaxers ○ Blood pressure medication ○ Insulin ○ Other (specify)

Vitamins/minerals/herbs/supplements:

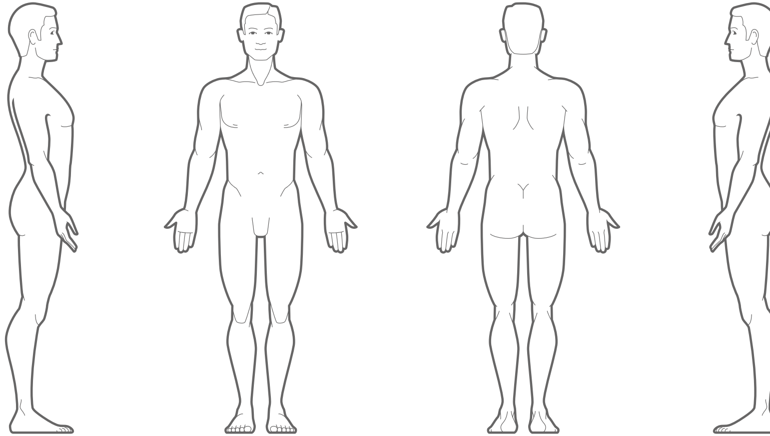
Do you suffer from any other conditions?

678.205.2313
terresahwangdc.com

DR. TERRESA HWANG
CHIROPRACTOR

PAIN DIAGRAM

Mark on the diagram where you currently have pain or other symptoms. Include symptoms of pain, numbness, tingling, etc.



MEDICAL HISTORY

Condition	Yes	No
Recent infection	○ Yes	○ No
Recent fever	○ Yes	○ No
HIV/AIDS	○ Yes	○ No
Diabetes	○ Yes	○ No
Corticosteroid use (inhaler)	○ Yes	○ No
Birth control pills	○ Yes	○ No
High blood pressure	○ Yes	○ No
Stroke (date)	○ Yes	○ No
Dizziness/fainting	○ Yes	○ No
Numbness in groin or buttocks	○ Yes	○ No
Urinary retension	○ Yes	○ No
Aortic aneurism	○ Yes	○ No
Cancer or tumor	○ Yes	○ No
Osteoporosis	○ Yes	○ No
Recent trauma	○ Yes	○ No
Prostate issues	○ Yes	○ No
Frequent urination	○ Yes	○ No
Pregnancy; number of births	○ Yes	○ No
Abnormal weight gain or loss	○ Yes	○ No
Epilepsy/seizures	○ Yes	○ No
Visual disturbances	○ Yes	○ No
History of back pain	○ Yes	○ No
History of neck pain	○ Yes	○ No
Arthritis	○ Yes	○ No
Alcohol use	○ Yes	○ No
Tobacco use	○ Yes	○ No
Surgeries (list below)	○ Yes	○ No

Family history: ○ Cancer ○ Diabetes ○ High blood pressure ○ Cardiovascular issues/stroke

Work activities: ○ Sit more than stand ○ Sit and stand equally ○ Stand more than sit

Previous auto injuries: ○ No ○ Yes (describe)

Previous work injuries: ○ No ○ Yes (describe)

Allergies:

Exercise habits: ○ None ○ Semi-regular program ○ Regular program (describe)

I certify that the above information is complete and accurate.
I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature

678.205.2313
terresahwangdc.com