

**Hengel Family Chiropractic, P.A.**  
**Gregory Hengel, Jr., D.C.**  
**1504 Kings Highway, Suite 300**  
**Port Charlotte, FL 33980**  
**941-629-0500**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
 STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 WORK PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
 MARITAL STATUS (circle one) married single divorced widowed  
 On-set of injury/ symptom: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Employment Related? \_\_\_\_

**MEDICAL HISTORY**

<u>YES</u>	<u>NO</u>	<u>DO YOU HAVE?</u>	<u>YES</u>	<u>NO</u>	<u>DO YOU HAVE?</u>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to any medications	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer or a tumor	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	History of radiation	<input type="checkbox"/>	<input type="checkbox"/>	Any other heart problem
<input type="checkbox"/>	<input type="checkbox"/>	History of chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia
<input type="checkbox"/>	<input type="checkbox"/>	History of surgery	<input type="checkbox"/>	<input type="checkbox"/>	History of blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Previous hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	History of any blood disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	History of ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	History of internal hemorrhage
<input type="checkbox"/>	<input type="checkbox"/>	Collagen Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or Vertigo
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	History of TIA
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	History of stroke
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness (black out)
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	History of seizures
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	History of Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headache
<input type="checkbox"/>	<input type="checkbox"/>	Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headache
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Other neurological problems
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction
<input type="checkbox"/>	<input type="checkbox"/>	History of rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency
<input type="checkbox"/>	<input type="checkbox"/>	History of heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Metal fragments in body
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently Pregnant?

Please list all conditions for which you are taking medication:

Smoking History Currently \_\_\_\_ Past \_\_\_\_ Years \_\_\_\_ Amount \_\_\_\_

Alcohol Yes No Amount \_\_\_\_ Substance Abuse Yes No Type \_\_\_\_

Should you become a patient, how will you be paying for your treatment? \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

I hereby authorize Dr. Gregory Hengel to provide service to me.

Patient Signature \_\_\_\_\_