CHIROPRACTIC INTAKE & HISTORY

HURST CHIROPRACTIC
· Natural Healthcare for Your Family ·

PATIENT INFORMATION

DC/CA

Name _____
(First) (Last) Preferred Name

Address _____

City _____ State _____

Home phone _____ Cell _____

Email _____

Sex ☐ M ☐ F Age ____ Date of birth _____

Marital status: M S W D SSN _____

Primary Care Physician _____ at _____

Person responsible for account _____

SSN _____ Employer _____

Employer / School _____

Spouse's Name _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

Signature _____

Would you like to receive our newsletter? ☐ Yes ☐ No

HOW CAN WE HELP YOU?

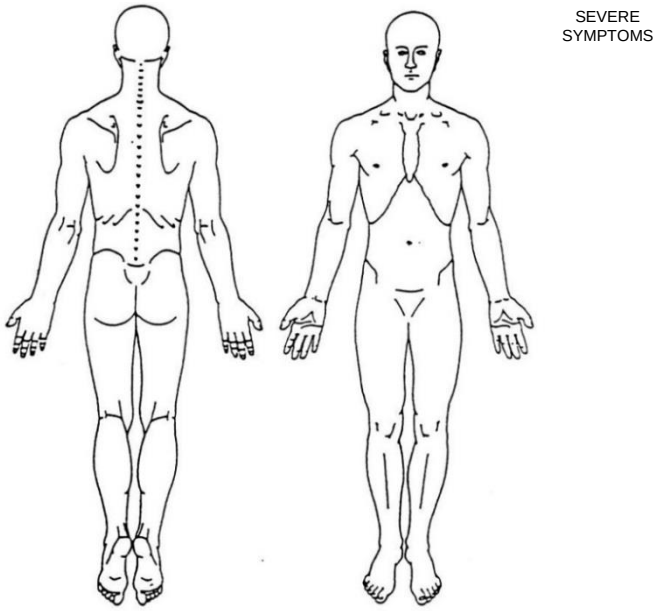
What brings you in today? _____

_____

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — SEVERE SYMPTOMS

Draw a line from the symptom to where you feel it:



Dull / Achy
Sharp / Stabbing
Burning
Shooting
Numbness / Tingling
Soreness
Stiffness / Tightness
Weakness
Cramping / Spasm
Other _____

Does anything make it better? _____

Does anything make it worse? _____

Who have you seen for this? No one Medical Doctor Other Chiropractor Physical Therapist Massage Therapist

What have you had done? ☐ Spinal X-rays ☐ MRI ☐ CT Scan ☐ Other _____ Where? _____

Have you had a similar problem in the past? ☐ No ☐ Yes _____

Name _____ Date _____ DC/CA_____

IMPACT OF YOUR SYMPTOMS

How is this 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	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue? ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NOT COMMITTED — VERY COMMITTED

HEALTH HISTORY

FAMILY HISTORY

Father's age ___ If deceased, age and cause of death _____

Mother's age ___ If deceased, age and cause of death _____

Does your family have a history of the following? (circle all that apply)

Cancer Heart Disease Liver Disease Kidney Disease Stroke

Lung Disease High Blood Pressure Scoliosis Other _____

GENERAL HISTORY

Alcohol: _____ drinks per ☐ day ☐ week ☐ month

Tobacco: _____ ☐ packs ☐ cans per day

Drug/substance dependence ☐ No ☐ Yes

Do you have a permanent disability rating? ☐ No ☐ Yes _____

Do you exercise on a regular basis? ☐ No ☐ Yes

_____ days per week. Type of activity _____

General stress level: Mild Moderate Severe

Occupation _____ Hours per week _____ ☐Retired

Primary work position: Seated Standing Other _____

Does your job require: Prolonged computer use Lifting

Overhead work Frequent bending Other _____

Are you currently pregnant? ☐ N/A ☐ No ☐ Yes, I am due _____

Number of past pregnancies _____

Health concerns regarding this pregnancy? _____

DIAGNOSED MEDICAL CONDITIONS (list)

_____

_____

_____

_____

_____

_____

PREVIOUS TRAUMA (list)

_____

_____

_____

_____

_____

MEDICATIONS (list)

_____

_____

_____

_____

_____

_____

SURGERIES / HOSPITALIZATIONS (list)

_____

_____

_____

_____

ALLERGIES (list)

_____

_____

_____

_____

Name _____ Date _____ DC/CA_____

REVIEW OF SYSTEMS

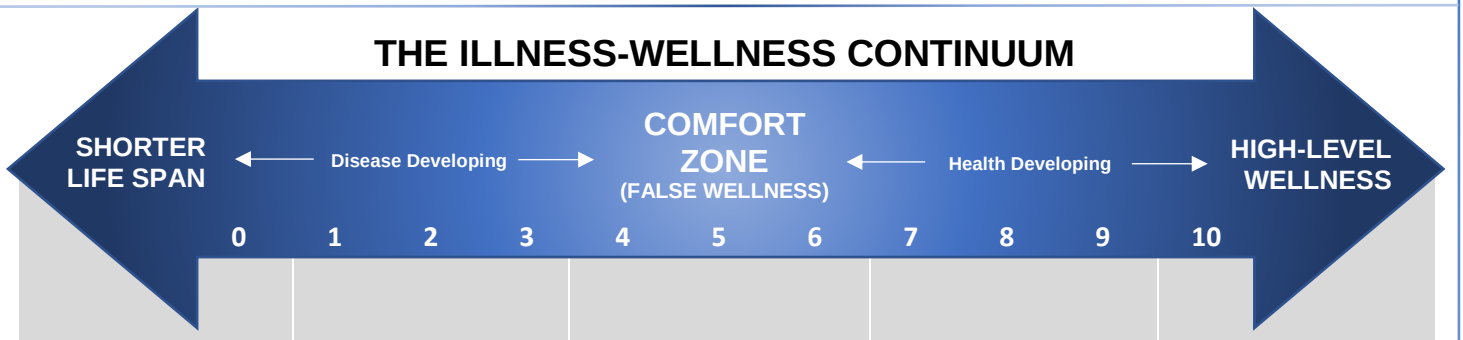
Please check the box beside any condition you have or have had.

- ☐ General fatigue
- ☐ Loss of sleep
- ☐ Headaches / Migraines
- ☐ Dizziness
- ☐ Weakness
- ☐ Fainting
- ☐ Nausea / Vomiting
- ☐ Memory loss or impairment
- ☐ Difficulty concentrating
- ☐ Depression (prolonged)
- ☐ Nervousness / Anxiety
- ☐ Thyroid trouble
- ☐ Chills (continuous)
- ☐ Tremor (shaking)
- ☐ Change in appetite
- ☐ Weight change (unplanned)
- ☐ Seizures
- ☐ Phobias (excessive fear)
- ☐ Diabetes
- ☐ Heartburn
- ☐ Heart trouble
- ☐ Difficulty breathing
- ☐ Poor circulation
- ☐ Chest pain
- ☐ Bruise easily
- ☐ Blood pressure high / low
- ☐ Varicose veins
- ☐ Hemorrhoids
- ☐ Abdominal pain
- ☐ Gall bladder problem
- ☐ Excess gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Enlarged glands
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Foot / Ankle issues
- ☐ Elbow / Wrist / Hand Issues
- ☐ Fever (continuous)
- ☐ Acne
- ☐ Hair / Nail changes
- ☐ Skin rash
- ☐ Nose or Sinus pain/infection
- ☐ Chronic nose bleeds
- ☐ Absence of smell
- ☐ Absence of taste
- ☐ Tonsillitis
- ☐ Difficulty swallowing
- ☐ Chronic cough
- ☐ Asthma
- ☐ Painful urination
- ☐ Inability to hold urine
- ☐ Frequent urination
- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Abnormal vaginal bleeding
- ☐ Sterility or impotence
- ☐ Night sweats
- ☐ Immune system issues
- ☐ Hearing trouble L R
- ☐ Ringing in ears L R
- ☐ Pain in ears L R
- ☐ Ear discharge L R
- ☐ Vision trouble L R
- ☐ Pain in eyes L R
- ☐ Eye discharge L R

☐ None of the above symptoms apply

PATIENT WELLNESS ASSESSMENT

THE ILLNESS-WELLNESS CONTINUUM



DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications	Symptoms	No symptoms	Regular exercise	100% function
Poor quality of life	Drug therapy	Nutrition inconsistent	Good nutrition	Continuous development
Limited potential	Surgery	Exercise sporadic	Wellness education	Active participation
Body's function limited	Losing normal function	Health not a high priority	Minimal nerve interference	Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

Name _____ Date _____ DC/CA_____

CONSULTATION NOTES (To be completed by office staff) **FILE #**

TRAUMA HX

MVCs:

Work:

Sports:

Misc:

REVIEW OF SYSTEMS

Neurological:

Musculoskeletal:

Gastrointestinal:

Lymphatic:

Hematological:

Respiratory:

Endocrine:

EENT:

Cardiovascular:

Genitourinary:

LIFE EFFECT

Work:

Exercise:

Recreation:

Relationships:

Sleep:

Self-care:

Energy/Attitude:

Productivity:

Other:

COMPLAINTS

	1°	*2°*	*3°*
Onset			
Aggravating			
Relieving			
Type			
Frequency			
Severity			
Referred			
Associated			