Hurst Chiropractic, P.C.
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CASE HISTORY

File#_____

PLEASE PRINT:

Name_____
(Last) (First) (MI) (Preferred Name)

Street Address_____Apt#_____City_____State____Zip_____
Mailing Address *(if other than above)* Rural Route#_____and/or P.O. Box_____City_____
Home Phone_____ Cell Phone _____E-mail Address_____
Date of Birth_____ Age___ Sex: M F Marital Status: M S W D Number of Children_____
Occupation_____Your Employer_____Work Phone_____
Social Security #_____ Name of Spouse/Partner _____
Primary Care Physician_____ at _____ None
Person responsible for account _____ Date of Birth _____
Social Security Number _____ Employer_____
Would you like to receive e-mail communication from our office? [ ] Yes [ ] No

Who can we thank for referring you to our clinic? _____
IN CASE OF EMERGENCY:
Relative or friend not living in your home_____Phone_____
I clearly understand and agree that I am personally responsible for full payment of all services rendered to me.

Patient's Signature_____ Date_____

HEALTH HISTORY

<u>Family History</u>

Father's age_____ If deceased, cause of and age at time of death_____
Mother's age_____ If deceased, cause of and age at time of death_____
Does your family have a history of any of the following *(circle all that apply)*:
Cancer Heart Disease Liver Disease Kidney Disease Lung Disease Mental Illness Diabetes
High Blood Pressure Stroke Scoliosis Other:_____

<u>Social History</u>

Tobacco _____ packs per day Alcohol _____ drinks per day / week / month
Drug/substance dependence: [ ] No [ ] Yes

<u>Occupational Information</u>

[ ] Employed: working _____ hours / week [ ] Unemployed [ ] Homemaker
[ ] Retired – former occupation_____ [ ] Student [ ] Disabled
Primary work posture: [ ] Seated [ ] Standing [ ] Other_____
Does your job require: [ ] Prolonged computer / phone use [ ] Frequent lifting [ ] Overhead work
Do you have a permanent disability rating? [ ] No [ ] Yes - Region of body: _____ Year:_____

<u>General</u>

Do you exercise on a regular basis? [ ] No [ ] Yes - Days per week_____ Type of exercise_____
Degree of physical activity (includes home and work): [ ] Light [ ] Moderate [ ] Heavy
Overall stress level: [ ] Mild [ ] Moderate [ ] Severe
Are you pregnant? [ ] N/A [ ] No [ ] Yes [ ] Maybe

Name_____ Date_____ DC/CA _____

Describe your symptoms_____

_____

_____

_____

When did your symptoms start?_____

How did your symptoms begin?_____

How often do you experience your symptoms?

Daily _____ 5-6 days per week_____

3- 4 days per week _____ 1-2 days per week_____

1-2 month_____ Other_____

Type of Symptoms – *(Draw a line from the symptom on the left to the area of the symptom)*

Sharp / Stabbing

Dull / Aching

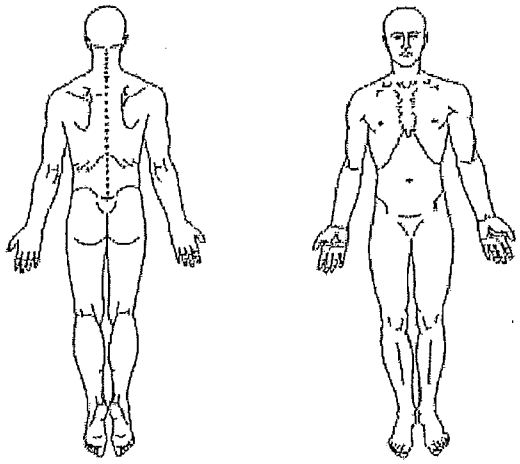
Burning

Tingling / Pins and Needles

Numbness

Shooting

Weakness



(Circle a # that corresponds to your symptom level and draw a line to the specific body part)

Symptom Level	
0	*None*
1	*Mild*
2	
3	
4	
5	*Moderate*
6	
7	
8	
9	
10	*Severe*

Is your pain or discomfort worsening? [ ] No [ ] Yes [ ] Same What, if anything, makes it worse?_____

_____

What, if anything, makes it better?_____

Does your condition interfere with? [ ] Sleep [ ] Work [ ] Daily Routine_____

_____

In general would you say your overall health right now is... *(Circle one)*

Excellent Very Good Good Fair Poor

Who have you seen for your symptoms? *(Circle all that apply)*

No one Medical Doctor Other Chiropractor Physical Therapist Massage Therapist Other_____

What have you done for your symptoms? *(Circle all that apply)*

Prescription Medication Over the counter medication Ice Heat Other_____

What tests have you had in the past? *(Date/location)*

Spinal X-rays:_____ MRI:_____ CT Scan:_____ Other:_____

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

DC/CA _____

REVIEW OF SYSTEMS

Are you currently suffering from any of the symptoms listed below? *(Check all that apply)*

- ❑ General Fatigue
- ❑ Weakness
- ❑ Fever (continuous)
- ❑ Loss of Sleep
- ❑ Weight Change (unplanned)
- ❑ Night Sweats
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Convulsions
- ❑ Nervousness/Anxiety
- ❑ Depression (prolonged)
- ❑ Phobias (excessive fears)
- ❑ Memory Loss or Impairment
- ❑ Difficulty Concentrating

	Left	Right
Hearing Trouble	o	o
Ringing in Ears	o	o
Pain in Ears	o	o
Ear Discharge	o	o
Vision Trouble	o	o
Pain in Eyes	o	o
Eye Discharge	o	o

- ❑ Nose/Sinus Pain
- ❑ Excessive Nasal Drainage
- ❑ Nose Bleeds (chronic)
- ❑ Nasal Infections (chronic)
- ❑ Absence of Smell
- ❑ Enlarged Glands
- ❑ Abnormal Taste Sensation
- ❑ Tonsillitis/Infected Tonsils
- ❑ Difficulty with Swallowing
- ❑ Diabetes
- ❑ Thyroid Trouble
- ❑ Tremor (shaking)
- ❑ Skin Rash
- ❑ Eczema (red, inflamed skin)
- ❑ Hair Changes (unplanned)
- ❑ Nail Changes (unplanned)
- ❑ Bruise Easily
- ❑ Acne
- ❑ Cough (chronic)
- ❑ Wheezing (chronic)
- ❑ Difficulty Breathing
- ❑ Asthma
- ❑ Chills (continuous)

- ❑ Heart Trouble
- ❑ Ankle Swelling
- ❑ Varicose Veins
- ❑ Blood Pressure High Low
- ❑ Chest Pain
- ❑ Poor Circulation
- ❑ Change in Appetite
- ❑ Abdominal Pain
- ❑ Hemorrhoids
- ❑ Excess Gas
- ❑ Nausea/Vomiting
- ❑ Diarrhea (excessive)
- ❑ Constipation (excessive)
- ❑ Heartburn/Indigestion
- ❑ Gall Bladder Problem
- ❑ Inability to Hold Urine
- ❑ Frequent Urination
- ❑ Bed-Wetting
- ❑ Irregular or Painful Menstruation
- ❑ Abnormal Vaginal Bleeding
- ❑ Sterility or Impotence
- ❑ Painful Urination

❑ None of the above-listed symptoms apply.

Have you had any spinal injuries in the past? *(car accident, slip/fall, concussion, etc.)* [ ] No [ ] Yes _____

_____

Have you had any surgeries or hospitalizations in the past? [ ] No [ ] Yes _____

_____

Current medications: *(list medication or condition you are medicated for)* _____

_____

General Notes: _____

_____

_____

_____

_____

_____

_____

_____

Patient's Signature _____ Date _____