Hurst Chiropractic, P.C.
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PEDIATRIC CASE HISTORY UPDATE

File#_____ Last Care_____

PLEASE PRINT:

Child's Name_____ Date_____
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_____

E-mail Address_____

Home Phone_____ Date of Birth_____ Age_____ Sex: Male Female

Father's Name _____ Occupation_____ Employer_____

Mother's Name _____ Occupation_____ Employer_____

Primary Care Physician_____ at _____ None

Does your child have Insurance with Chiropractic Benefits? No [ ] Yes [ ]

Name of Ins. Company_____ Group#_____ ID#_____

Subscriber_____ Subscriber's Date of Birth_____

Subscriber's SS# _____ Person responsible for account_____

Would you like to receive e-mail communication from our office? [ ] Yes [ ] No

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 my child.

Parent/Guardian's Signature_____

D/I or D/O_____ MVA [ ] School [ ] Sports [ ] Home [ ] Unknown [ ] Other [ ]

Description_____

_____

_____

_____

Worsening? No [ ] Yes [ ] Same [ ] Comes and goes [ ] Aggravated by:_____

Does condition interfere with: Sleep [ ] Daily activities [ ]_____

Previous treatment for this condition? Results? _____

X-ray? No [ ] Yes [ ] _____ Where?_____

Similar problem in the past? No [ ] Yes [ ]_____

Previous spinal injury? No [ ] Yes [ ]_____

Medications or drugs? No [ ] Yes [ ]_____

Surgery? No [ ] Yes [ ]_____

Other health issues or history_____

_____

Observation: Alert? Yes [ ] No [ ]_____ Cooperative? Yes [ ] No [ ]_____

_____ *CT/DC Initials*_____

REVIEW OF SYSTEMS

Are you currently suffering from any of the symptoms listed below?

- ❑ 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)

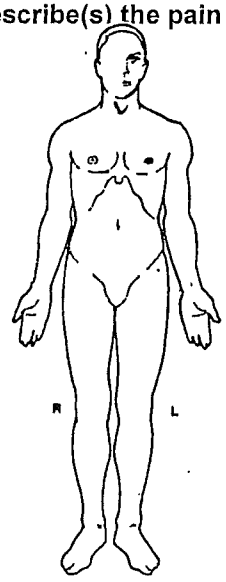
- ❑ Heart Trouble
- ❑ Ankle Swelling
- ❑ Varicose Veins
- ❑ Blood Pressure High Low
- ❑ Chest Pain
- ❑ Poor Circulation
- ❑ Change in Appetite
- ❑ Abdominal Pain
- ❑ Hemorrhoids
- ❑ Excess Gas
- ❑ Nausea/Vomiting
- ❑ Diarrhea (excessive)
- ❑ Constipation (excessive)
- ❑ Heartburn/Indigestion
- ❑ Gall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

_____

❑ None of the above-listed symptoms apply.

PAIN DRAWING

ıstructions: On the illustrations below, please shade in your area(s) of pain or discomfort and draw a line to the word or ords that best describe(s) the pain or discomfort.



Sharp / Stabbing

Dull / Aching

Burning

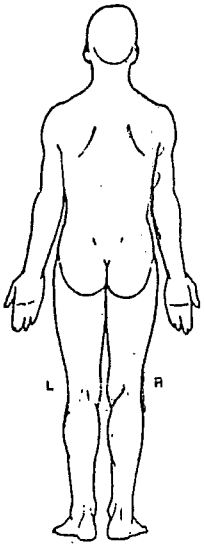
Tingling / Pins and Needles

Numbness

Constant

Comes and Goes

Other:_____



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

_____

)es your condition interfere with? [ ] Sleep [ ] Work [ ] Daily Routine_____

)scribe:_____

Patient's Signature_____ Date_____