

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

Who can we thank for referring you to our clinic? _____

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

Should you enjoy your experience with us and choose to refer friends or family, we want to reward you. Of the following, which type of gift card would you most appreciate? Target Lowes Starbucks

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

Family History

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: _____

Social History

Tobacco _____ packs per day Alcohol _____ drinks per day / week / month

Drug/substance dependence: No Yes

Occupational Information

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: _____

General

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)

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

Sharp / Stabbing

Dull / Aching

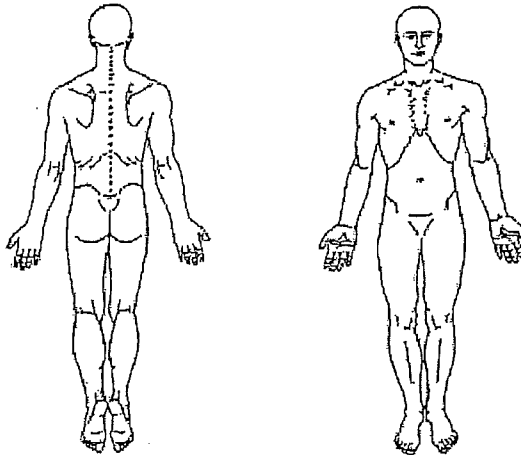
Burning

Tingling / Pins and Needles

Numbness

Shooting

Weakness



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 since your last visit with us? (Date/location)

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

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

REVIEW OF SYSTEMS

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

- | | | |
|--|---|--|
| <input type="checkbox"/> General Fatigue | <input type="checkbox"/> Nose/Sinus Pain | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Excessive Nasal Drainage | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Fever (continuous) | <input type="checkbox"/> Nose Bleeds (chronic) | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Nasal Infections (chronic) | <input type="checkbox"/> Blood Pressure High Low |
| <input type="checkbox"/> Weight Change (unplanned) | <input type="checkbox"/> Absence of Smell | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abnormal Taste Sensation | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tonsillitis/Infected Tonsils | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty with Swallowing | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excess Gas |
| <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Depression (prolonged) | <input type="checkbox"/> Tremor (shaking) | <input type="checkbox"/> Diarrhea (excessive) |
| <input type="checkbox"/> Phobias (excessive fears) | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Constipation (excessive) |
| <input type="checkbox"/> Memory Loss or Impairment | <input type="checkbox"/> Eczema (red, inflamed skin) | <input type="checkbox"/> Heartburn/Indigestion |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Hair Changes (unplanned) | <input type="checkbox"/> Gall Bladder Problem |
| | <input type="checkbox"/> Nail Changes (unplanned) | <input type="checkbox"/> Inability to Hold Urine |
| | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Urination |
| Hearing Trouble | Left Right | <input type="checkbox"/> Bed-Wetting |
| | o o | <input type="checkbox"/> Irregular or Painful Menstruation |
| Ringing in Ears | o o | <input type="checkbox"/> Abnormal Vaginal Bleeding |
| Pain in Ears | o o | <input type="checkbox"/> Sterility or Impotence |
| Ear Discharge | o o | <input type="checkbox"/> Painful Urination |
| Vision Trouble | o o | <input type="checkbox"/> Allergies |
| Pain in Eyes | o o | |
| Eye Discharge | o o | |

None of the above-listed symptoms apply.

Have you had any spinal injuries in the past? (car accident, slip or 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 _____