

Hurst Chiropractic, P.C.

1120 GRANT ROAD EAST WENATCHEE, WASHINGTON 98802 (509) 884-7163 Fax: (509) 884-2363 www.HurstClinic.com

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

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 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?

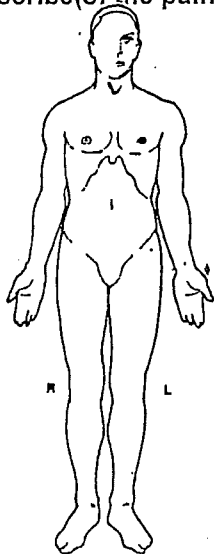
- | | | |
|--|--|--|
| <input type="checkbox"/> General Fatigue
<input type="checkbox"/> Weakness
<input type="checkbox"/> Fever (continuous)
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Weight Change (unplanned)
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Headaches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

	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

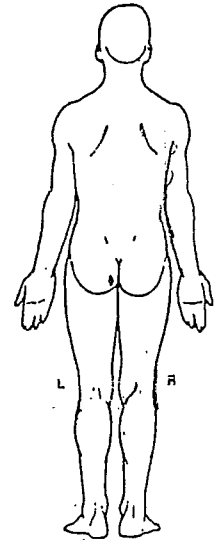
None of the above-listed symptoms apply.

PAIN DRAWING

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



- Sharp / Stabbing
- Dull / Aching
- Burning
- Tingling / Pins and Needles
- Numbness
- Constant
- Comes and Goes



Other: _____

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

Does your condition interfere with? [] Sleep [] Work [] Daily Routine _____

Describe: _____

Patient's Signature _____

Date _____