

# Hurst Chiropractic, P.C.

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## CASE HISTORY UPDATE

PLEASE PRINT:

File# \_\_\_\_\_ Last Care \_\_\_\_\_

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

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

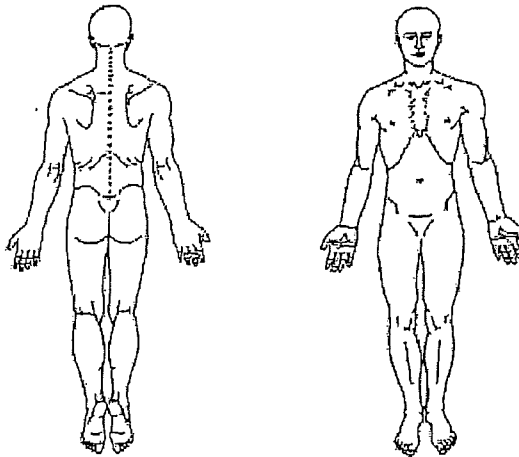
Burning

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                |
|  | <input type="checkbox"/> Acne                         | <input type="checkbox"/> Bed-Wetting                       |
|  | <input type="checkbox"/> Cough (chronic)              | <input type="checkbox"/> Irregular or Painful Menstruation |
|  | <input type="checkbox"/> Wheezing (chronic)           | <input type="checkbox"/> Abnormal Vaginal Bleeding         |
|  | <input type="checkbox"/> Difficulty Breathing         | <input type="checkbox"/> Sterility or Impotence            |
|  | <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Painful Urination                 |
|  | <input type="checkbox"/> Chills (continuous)          | <input type="checkbox"/> Allergies                         |

	Left	Right
Hearing Trouble	<input type="radio"/>	<input type="radio"/>
Ringing in Ears	<input type="radio"/>	<input type="radio"/>
Pain in Ears	<input type="radio"/>	<input type="radio"/>
Ear Discharge	<input type="radio"/>	<input type="radio"/>
Vision Trouble	<input type="radio"/>	<input type="radio"/>
Pain in Eyes	<input type="radio"/>	<input type="radio"/>
Eye Discharge	<input type="radio"/>	<input type="radio"/>

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 \_\_\_\_\_