Welcome to Hurst Chiropractic.

Name _____ Birth date ____/____/____ Age_____

Male/ Female Height_____ Weight_____ Drivers' Lic. #_____

Address_____ City _____ State___ Zip_____

Telephone_____ Cell_____ E-Mail _____

Marital Status M S O D Number of children_____ Occupation_____

Spouse's Name_____Occupation_____

In case of an Emergency, call_____ At _____

Person Responsible For Account _____

CONDITION THAT BRINGS YOU IN TODAY!

What is your major complaint? _____

How long have you had this condition _____ Is it Constant Y/N

Circle type of pain: Achy, Sharp, Dull, Throbbing, Shooting, Numbness, Tingling

Rate your pain from 0 to 10 (0 being no pain; 10 the worst possible pain)

1 2 3 4 5 6 7 8 9 10

What aggravates your Condition? _____

What makes this condition feel better? _____

Do you have any other symptoms that you believe to be associated with this condition

Yes/No What are they_____

Doctors that you have seen for this condition Name _____Telephone_____

Diagnosis_____ Is this your Primary Doctor? Yes/No

Are you currently taking any prescription medication for this condition or others?

Yes/ No If so, list these: _____

Are you taking any nutritional supplements (vitamins, herbs) Yes/ No

If so, list these:

_____

Are you exercising Y/N What type _____

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Do you have a History of:

Smoking? Y/ N Years_____ Packs/Day_____ Alcohol? Y/ N Amount/Week_____

Allergies_____ Fractures _____ Any History

of dizziness or Fainting Yes/No When _____

Surgeries _____Year _____ Hospitalizations Yes/No Year _____

Major Illnesses in your family. Yes/No? What are they: _____

Are you paying cash _____or using Insurance?

Insurance _____ Member ID _____

Primary Card Member _____ Date of Birth _____

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HEAD:
- Headaches
  - [] sinus allergy
  - [] entire head
  - [] back of head
  - [] forehead
  - [] temples
  - [] migraines
- [] head feels heavy
- [] loss of memory
- [] light headedness
- [] fainting
- [] light bothers eyes
- [] blurred vision
- [] doubled vision
- [] loss of vision
- [] loss of taste
- [] loss of hearing
- [] loss of balance
- [] dizziness
- [] pain in ears
- [] ringing in ears

NECK:
- [] pain with movement
  - [] forward
  - [] backward
  - [] side R/L
- [] pinched nerve
- [] feels out of place
- [] muscle spasms
- [] grinding sounds
- [] popping sounds
- [] arthritis

SHOULDERS:
- [] pain in joint R/L
- [] pain across shoulders
- [] bursitis R/L
- [] arthritis R/L
- [] can't raise arm
  - [] above shoulder
  - [] over head
- [] tension in shoulders
- [] pinched nerve R/L
- [] muscle spasms

ARM & HANDS:
- [] pain in upper arm
- [] pain in elbow
- [] movement aggravated
- [] tennis elbow
- [] pain in forearm
- [] pain in hands
- [] pain in fingers
- [] pins & needles in arms
- [] pins & needles in fingers
- [] hands go cold or go to sleep
- [] swollen/sore joints in fingers
- [] arthritis in fingers
- [] loss of grip strength

MID-BACK:
- [] Mid-Back Pain
- [] Location: _____
- [] Type of Pain? _____
- [] Muscle spasms
- [] Pain in kidney area

CHEST:
- [] Chest pain
- [] Shortness of breath
- [] Pain around ribs
- [] Breast pain
- [] Irregular heart beat

ABDOMEN:
- [] Nervous stomach
- [] Foods can't eat? _____
- [] Nausea
- [] Gas
- [] Constipation
- [] Diarrhea
- [] Hemorrhoids

LOW BACK:
- [] Upper Lumbar
- [] Lower Lumbar
- [] Sacroiliac

Low Back Pain Worse when
- [] walking
- [] lifting
- [] stooping/bending
- [] standing
- [] sitting
- [] coughing
- [] lying down
- [] working

Pain Relieved when _____
- [] Slipped Disc
- [] Feels out of place
- [] Muscle spasms
- [] Arthritis

HIPS, LEGS, & FEET:
- [] Pain in buttocks R/L
- [] Pain in hip joint R/L
- [] Pain down leg R/L
- [] Knee pain R/L
  - where? _____
- [] Leg cramps
- [] Cramps in feet R/L
- [] Pins & needles in legs R/L
- [] Pins & needles in feet, toes R/L
- [] Numbness
- [] Feet feel cold
- [] Swollen ankles
- [] Swollen feet

WOMEN:
- [] Menstrual pain
  - where? _____
- [] Cramping
- [] Irregularity
- [] Cycle ____ Days
- [] Birth Control
  - type? _____
- [] Hysterectomy
- [] Genital Cancer
- [] Discharge
- [] Menopause
  - when? _____
- [] Tumors
- [] Abortions
- [] Do you think you may be pregnant? _____

MEN:
- [] Urinary frequency
- [] Difficulty in starting stream
- [] Night urination
- [] Prostate pain/swelling

GENERAL:
- [] Nervousness
- [] Irritability
- [] Depressed
- [] Fatigue
- [] Generally feel run down
- [] Normal sleep hours: _____
- [] Loss of sleep
- [] Loss of weight: _____ lbs
- [] Gain of weight: _____ lbs
- [] Coffee: _____ cups per day
- [] Tea: _____ cups per day
- [] Soda _____ cups per day
- [] Water _____ cups per day
- [] Cigarettes _____ packs per day for _____ years
- [] Diabetes
- [] Hypoglycemia
- [] Vegetarian
- [] Excessive night time urination
- [] Other Health Concerns:

_____
_____
_____
_____
_____

Date_____