Hornell Chiropractic and Wellness

WELCOME

PERSONAL INFORMATION

Today's Date : _____ / _____ / _____

Full Name : _____ **Preferred Name** : _____
LAST FIRST MI

Date of Birth : _____ / _____ / _____ **Age** : _____ **Gender** : ☐ Male ☐ Female

Address : _____ **Cell Phone** : _____

_____ **Work Phone** : _____
CITY STATE ZIP

E-Mail : _____ **Home Phone** : _____

Referred By : ☐ Web/Google ☐ Facebook ☐ Current Patient ☐ Friend/Family ☐ Other : _____

Status : ☐ Single ☐ Married ☐ Divorced ☐ Minor ☐ Other : _____

Employment : ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Other : _____

Employer : _____ **Occupation** : _____

Spouse's Name : _____ **Do you have children?** ☐ yes ☐ no **If yes, how many?** _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Home Number** : _____

Relationship : _____ **Mobile Number** : _____

Medical Doctor : _____ **Doctor's Phone** : _____

REASON FOR VISIT

Reason for today's visit : ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness

Are you in pain : ☐ yes ☐ no **Rate your pain** : discomfort 1 2 3 4 5 6 7 8 9 10 intense

Quality of Pain (circle one) : Ache / Burn / Cramp / Pins & Needles / Pain / Sharp or Stabbing / Stiff / Other: _____

Did your injury occur during : ☐ Work ☐ Sports/play ☐ Auto accident ☐ Routine Household activity

Date of Injury : _____ / _____ / _____ **Where did your injury occur?** : _____

Please explain what happened : _____

Is your condition getting worse? : ☐ yes ☐ no ☐ constant ☐ comes and goes

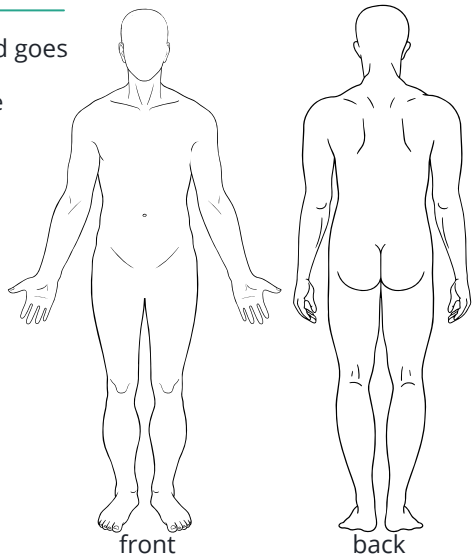
Is your condition interfering with your : ☐ work ☐ sleep ☐ Daily routine

If so how? : _____

Has something similar happened in the past? ☐ yes ☐ no

Explain : _____

<u>Using the adjacent body charts, please circle all affected areas.</u>



Have you been treated by a Medical Physician for this condition?

☐ yes ☐ no **If so, where?** : _____

Have you ever been treated by a Chiropractor? ☐ yes ☐ no

Clinic or Dr's name : _____

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HEALTH HISTORY

Are you taking any of the following medications? : ☐ Nerve pills ☐ Pain killers (incl aspirin) ☐ Muscle relaxers ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Others: _____

Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart Attack / Stroke
Y N Mitral Valve Prolapse
Y N HIV+ / AIDS / ARC
Y N Anemia / Diabetes
Y N Kidney Problems
Y N Shingles
Y N High/Low Blood Pressure
Y N Ulcers / Colitis
Y N Heart Surg./Pacemaker
Y N Artificial Valves
Y N Alcohol/Drug Abuse
Y N Cancer
Y N Psychiatric Problems
Y N Fainting, Seizures, Epilepsy
Y N Chemotherapy
Y N Difficulty Breathing
Y N Heart Murmur
Y N Venereal Disease
Y N Frequent Neck Pain
Y N Rheumatic Fever
Y N Sinus Problems
Y N Lower Back Problems
Y N Tuberculosis
Y N Congenital Heart Defect
Y N Hepatitis
Y N Glaucoma
Y N Severe / Frequent Headaches
Y N Emphysema / Asthma
Y N Artificial Bones/Joints/Implants
Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list any allergies: _____

Family Health History: _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Other: _____

Do you take supplements or vitamins? ☐ yes ☐ no **Do you exercise?** ☐ yes ☐ no _____ hours per week

Do you smoke? ☐ yes ☐ no **How much?** _____ **How long?** _____ **Are you dieting?** ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no **How much?** _____ **Are you wearing:** ☐ Shoe lifts ☐ Arch supports

FOR WOMEN **Are you taking birth control?** ☐ yes ☐ no **Are you pregnant?** ☐ yes ☐ no
Are you nursing? ☐ yes ☐ no **If yes, how many weeks?** _____

HOW CAN WE HELP YOU TODAY?

What is the number one issue you are here for today? _____

Is there anything else you would like us to know? _____

What can we do to make you happier? _____

CONSENT AND ACKNOWLEDGEMENT

The information above is true and complete to the best of my knowlege.

Signed : _____ **Today's Date** : _____ / _____ / _____

TELL US MORE ABOUT YOUR HEALTH CARE NEEDS

Are you interested in any of the other wellness services we offer?

◯ High Quality Supplements
◯ Weight Loss
◯ Food and Nutrition Guidance
◯ Nutrition Response Testing
◯ Massage Therapy
◯ Custom Arch Supports
◯ Natural Pain Relief
◯ Ways to Reduce Inflammation
◯ Free Health Education Talks
◯ PEMF and Red Light Therapy
◯ Traction / Spinal Decompression
◯ DIY Health Improvement Tools

What other services could we offer to better support your wellness goals? _____