HP Spine Center

Patient Information & History

Name: ____ Date: _____/_____/_____
(First) (Initial) (Last) (Name to be called)

Address: __________________________________ Home Phone: _____-_____-_______
__________________________________ Work Phone: _____-_____-_______
(City) (State) (Zip) Cell Phone: _____-_____-_______

Email: ________________@____________________

In case of emergency, contact:
____
Phone: _____-_____-_______

Birthday: ____/____/____ Age: ____ Male___ Female___

Parents (if a minor): ____________________________

Marital Status: Single___ Married___ Divorced___ Widowed___

Spouse's Name: ___________ Children: __Yes __ No #_____

Occupation: _______________________ Employer: ______________________

Who may we thank for referring you? ____

Is your condition possibly due to an accident? Yes___ No___ Date: ____/____/____

If yes, what type of accident? Automobile___ Work____ Other________________

To whom have you reported the accident? Insurance__ Worker's Comp__ Employer__ Other__

What is your major symptom/problem? __________________
____

When did your symptoms begin? ______________________

Have you had this problem before? ____________________

Is your condition getting progressively worse? Yes___ No___

Is this problem: ___constant ___comes and goes

Circle below the severity of your pain on a scale of 0 to 10:

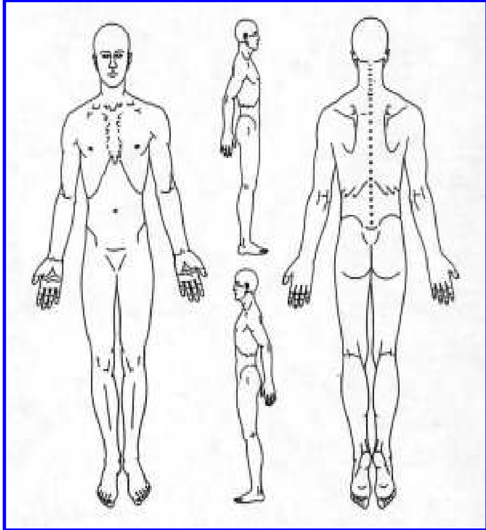
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

What makes your condition better? ____________________

What makes your condition worse? ____________________

Activities/movements that are painful to perform:

___Sitting ___Standing ___Walking ___Bending ___Lying down



Mark an "X" on the picture where you have pain and/or numbness:

TURN OVER TO BACK

Check any treatments you have had for this condition:

___Chiropractic ___Orthopedic ___Neurologist ___Physical Therapy ___Medication ___Surgery

Names of other doctors who have treated your condition: ________________________________

____

Describe other doctor's treatment for your condition: ________________________________

Previous Chiropractic care? ___Yes ___No If yes, what type(s) of chiropractic? ____________

____

Date of last: Physical exam __________ Spinal x-ray __________ MRI __________

Spinal exam __________ Dental x-ray __________ CT-scan __________

List any medications you are currently taking: ____

Are you pregnant? ___Yes ___No Beginning of last menstrual cycle: ____________

Check any of the following conditions you have had:

___AIDS/HIV
___Allergies
___Anxiety/Depression
___Arm/shoulder pain
___Arthritis
___Asthma
___Bladder problems
___Cancer
___Chronic fatigue
___Deafness
___Diabetes
___Digestion problems
___Earache
___Ear ringing
___Epilepsy
___Headaches
___Headaches - Migraine
___Heart Disease
___Hemorrhoids
___Herniated disk
___High blood pressure
___Insomnia
___Irregular cycle
___Kidney problems
___Leg pain
___Low back pain
___Neck pain
___Numbness
___Osteoporosis
___Poor circulation
___Prostate problems
___Rheumatoid Arthritis
___Sciatica
___Shingles
___Sinus infection
___Stroke
___Thyroid problems
___TMJ
___Vertigo/Dizziness

Have you had any:	**Description**	**Date**
Automobile accidents	______________________________	__________
Surgeries	______________________________	__________
Broken bones	______________________________	__________
Falls/Head injuries	______________________________	__________

This office accepts cash, checks, MasterCard, Visa, American Express, and Discover. To keep our fees reasonable, payment is expected at the time of service. Health and auto insurance policies are arrangements between the patient and the insurance carrier. This office does not accept insurance, but will file your insurance claims electronically if you have chiropractic benefits.

I hereby authorize the release of any information regarding my treatment to my insurance company or myself.

______________________ ____________ ______________________

Signature Date Parent (if patient is a minor)