

Welcome to Hawthorne Chiropractic!

Please take a moment to provide us with the following information.

If you have any questions, please let one of us know.

TODAY'S DATE _____

ABOUT YOU

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age _____ Date of Birth: _____

SSN: _____

Occupation _____ Daily # of hrs worked: _____

Work Activities: _____

Employer _____

How did you hear about us? _____

If a person referred you, we will thank them with a free 30-minute massage or chiropractic treatment.

ACCIDENT INFORMATION

If this is related to an accident, please let us know about it here.

Type of accident?

Work Auto Other

Attorney's Name: _____

Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

(There is an additional form for auto accident victims which needs to be completed)

CASH ACCOUNT

If you are not covered by insurance, please indicate who will be responsible for payment.

Name: _____

Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

PHONE NUMBERS

Home: _____

Work: _____

Is it OK to call you at Work Yes No

Mobile: _____

E-mail: _____

Emergency Contact

Name: _____

Relationship: _____

Home #: _____

Work and/or cell #: _____

Primary Care Physician: _____

their ph # (if you know it): _____

INSURANCE INFORMATION

Name of insured? _____

Birth Date (of insured): _____

SSN#: _____

Relationship to patient: _____

Insurance Co: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional Insurance? _____

Subscriber's Name: _____

Birth Date: _____ SSN#: _____

Relationship to patient: _____

Insurance Co: _____

Address: _____

(We must have a photocopy of both sides of your insurance card(s))

CHIEF COMPLAINTS

Please check all answers and fill in the blanks where appropriate. In the space below, below, please describe the present complaints which brought you to this clinic for care. After completing page 1 please complete page 2. The information you provide helps your doctor provide you with the highest level of care.

	Present Complaint A	Present Complaint B
1. Please describe your complaint:		
2. Please describe the character of your current pain (Check all that apply):	<input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Electrical <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Burning <input type="checkbox"/> Soreness <input type="checkbox"/> Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Throbbing <input type="checkbox"/> Gnawing <input type="checkbox"/> Numb/Tingling	<input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Shooting <input type="checkbox"/> Electrical <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Burning <input type="checkbox"/> Soreness <input type="checkbox"/> Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Throbbing <input type="checkbox"/> Gnawing <input type="checkbox"/> Numb/Tingling
3. How often are the complaints present?	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent (51-75%) <input type="checkbox"/> Occasional (26-50%) <input type="checkbox"/> Intermittent (25% or less)	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent (51-75%) <input type="checkbox"/> Occasional (26-50%) <input type="checkbox"/> Intermittent (25% or less)
4. How bad is your pain or ache? Please circle number:	(No pain) 0-1-2-3-4-5-6-7-8-9-10 (unbearable pain)	(No pain) 0-1-2-3-4-5-6-7-8-9-10 (unbearable pain)
5. Since your problem began is the pain:	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> Not Changing	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> Not Changing
6. When did your problem begin: (Specific date)		
7. Did your problem begin:	<input type="checkbox"/> Immediately after a specific incident <input type="checkbox"/> Multiple incidents <input type="checkbox"/> Gradually developed over time <input type="checkbox"/> No specific reason	<input type="checkbox"/> Immediately after a specific incident <input type="checkbox"/> Multiple incidents <input type="checkbox"/> Gradually developed over time <input type="checkbox"/> No specific reason
8. Describe how your problem began:		
9. What treatment have you received for this present condition?	<input type="checkbox"/> None <input type="checkbox"/> Surgery <input type="checkbox"/> Injections <input type="checkbox"/> Therapy from a PT <input type="checkbox"/> Brace/support <input type="checkbox"/> Medications _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> None <input type="checkbox"/> Surgery <input type="checkbox"/> Injections <input type="checkbox"/> Therapy from a PT <input type="checkbox"/> Brace/support <input type="checkbox"/> Medications _____ <input type="checkbox"/> Other _____
10. Were you previously treated for a different occurrence of this same condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by: <input type="checkbox"/> Chiropractor <input type="checkbox"/> MD <input type="checkbox"/> Therapist Name of person who treated you: _____ <input type="checkbox"/> Other _____ (specify dates & type of treatment with results)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by: <input type="checkbox"/> Chiropractor <input type="checkbox"/> MD <input type="checkbox"/> Therapist Name of person who treated you: _____ <input type="checkbox"/> Other _____ (specify dates & type of treatment with results)
11. What makes your problem better?	<input type="checkbox"/> Nothing <input type="checkbox"/> Lying down <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Movement/Exercise <input type="checkbox"/> Inactivity <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Change of Position or getting up <input type="checkbox"/> Other _____	<input type="checkbox"/> Nothing <input type="checkbox"/> Lying down <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Movement/Exercise <input type="checkbox"/> Inactivity <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Change of Position or getting up <input type="checkbox"/> Other _____
12. What makes your problem worse?	<input type="checkbox"/> Nothing <input type="checkbox"/> Lying down <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Movement/Exercise <input type="checkbox"/> Inactivity <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Change of Position or getting up <input type="checkbox"/> Other _____	<input type="checkbox"/> Nothing <input type="checkbox"/> Lying down <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Movement/Exercise <input type="checkbox"/> Inactivity <input type="checkbox"/> Rolling over in bed <input type="checkbox"/> Change of Position or getting up <input type="checkbox"/> Other _____

Name:

DOB:

LIFESTYLE / HABITS HISTORY

1. How would you grade your general stress level?

No stress Minimal Stress Moderate stress Greatly stressed

2. Physical activity activity at work:

More than 50% Sedentary Light manual labor Manual Labor Heavy manual labor

3. General physical activity:

No regular exercise program Light exercise program Strenuous program

Type of exercise and frequency: _____

4. Is your diet healthy enough? Yes No Not Sure Need Help

5. What position do you sleep in? Back Stomach Left side Right side

5. Average hours of sleep a night: _____

6. What type of bed do you have?

Futon, Tempurpedic®, Spring coil standard mattress, etc. _____

7. Do you awaken feeling rested? Yes No **Sore & Stiff?** Yes No

Approx. height of pillow < 2 in. 2-4 in. > 5 in.

8. Are you wearing? Heel lift _____ Sole lift _____ Inner sole arch supports _____

9. Are your complaints affecting your ability to work or otherwise be active?

- No effect Need limited assistance with common everyday task
- Have significant inability to function without assistance
- Some physical restriction (able to perform light duty work and household task)
- Need assistance often Totally disabled (impaired) Cannot care for self

10. Have you ever been under the care of a chiropractor before? Yes No

If yes, for what condition(s)? _____

When was your last treatment? _____

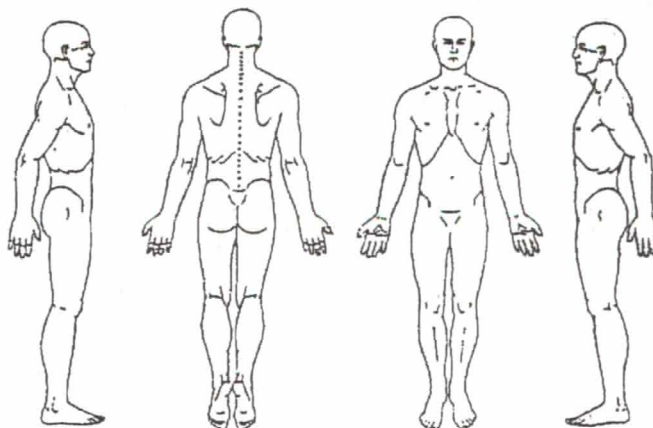
11. Domestic:

Children? Yes No

If Yes, what ages? _____

Supportive partner? Yes No

Circle on the picture where you have pain or other symptoms, including numbness or tingling.



Name: _____ **DOB:** _____

Health History

When was your most recent full physical, including heart/lung/BP, etc.: _____

Results: _____

If you ever had a listed symptom in the *past*, please check that symptom in the Past column, If you are presently troubled by a particular symptom, check that symptom in the *Present* column.

- | Past | Present | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling/Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting, Visual Disturbance, Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Irregular Bowel Habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Soreness/Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash |

- | Past | Present | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol use How often: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Vitamins/herbs |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgical Procedures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/ Caffeinated soft drink, cups per day: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you adhere to any dietary restrictions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a smoker? How long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | How much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a permanent disability rating? |
| | | Location _____ |
| | | Date rating received _____ / _____ / _____ |
| | | Rating percentage _____ % |

Men only

- Prostate exam, including blood test
 Problems with prostate

Women only

- Irregular Periods
 Periods Have Ceased
 Profuse Menstrual Flow
 Vaginal Discharge
 PMS
 Birth Control Pill
 Periods Accompanied by Abdominal Pain
 Severe and Incapacitating (you go to bed)
 Gynecological or Abdominal Surgeries
 Breast Soreness/Lumps
 Pregnancy
 Have Any Children? *If yes: what ages:* _____

Your current weight: _____ lbs. / Height: _____ feet _____ inches

Please list anything that you may be allergic to: _____

List any serious accident dates: _____

Please list dates of X-Rays, CAT Scans, MRI's or any other studies done: _____

Please list all medicines you are presently taking, and why: (Use back if necessary.) _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

- | Past | Present | | Past | Present | | Past | Present | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Anorexia | <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Defect/Murmur | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Unexplained weight loss/gain, fever, fatigue (circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders | | | |

Do you have any known contagious diseases at this time? If yes, What: _____

Name: _____ **DOB:** _____