

HCW

Hornback Chiropractic & Wellness, P.A.

Patient Information

Name _____ Date _____
Age _____ Date of Birth _____
Address _____
City/Town _____ State _____ Zip _____
Home Phone () _____ Cell Phone () _____ Work Phone () _____
Sex: M F Email _____ Social Security Number _____
Occupation _____ Employer Name _____
Address _____
City/Town _____ State _____ Zip _____

Marital Status

Single Married Divorced Widowed
Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer Name _____
Contact Phone () _____ E-Mail Address _____
Please check to disclose appointments medical records to name: _____ Relation: _____

Number of Children _____

Please list your children's names and ages _____

Family Medical Doctor's _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding you care at this office?
 Yes No

Reason for consulting Hornback Chiropractic & Wellness _____

Whom or who may we thank for referring you to our office? _____

Your Health Profile - *Why do we ask you to fill out this form?*

As a full-service chiropractic wellness center, we focus on your ability to do the following: Move well. Eat well. Think well. We not only want to address the issues that brought you to our office, but we also want to offer you opportunities for improved health potential and overall wellness in the future. Answering the following questions will give us a profile of the specific stresses you have faced during your lifetime, allowing us to better assess the challenges to your health potential.

Beginning Years (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability:

Did you have any childhood illnesses?

YES NO UNSURE

- Did you have any serious falls as a child?
- Did you take or use any drugs?
- Did you play youth sports?
- Did you undergo any surgery?
- Were you involved in any auto accidents as a child?
- Have you fallen or jumped from a height over three feet (i.e. from crib, trees, etc.)?
- Were you vaccinated?
- Was there any prolonged use of medicine, such as an inhaler or antibiotics?
- Did you suffer any other traumas, physical or emotional?
- As a child, were you under regular chiropractic care?

Addressing the Issues That Brought You to HCW

Date symptoms appeared or accident happen? _____

Is this due to: Auto Work Other _____

Have you ever had the same or similar condition? Yes No

If yes, when and describe _____

How frequent is the condition? Constant Daily Intermittent Night Only

Is there anything you can do to relieve the problem? Yes No

If yes, describe _____

If no, what have you tried? _____

Grade of intensity/severity: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

If you are experiencing pain, is it:

- Sharp Dull
- Comes and Goes Travels
- Constant

Since the problem started, it is:

- About the Same Getting Better
- Getting Worse

What makes the problem worse? _____

The problem interferes with:

- Walking Work
- Sleep Sitting
- Hobbies Leisure

Please list other doctors or health professionals seen for this problem.

- Chiropractor _____
- Medical Doctor _____
- Other _____
- Other _____

Please list any medications that you are taking currently:

Family Health Profile

We are not only interested in YOUR health and well-being but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

- Children _____
- Spouse _____
- Mother _____
- Father _____
- Brothers _____
- Sisters _____
- Others _____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

- Ulcers Mood Swings
- Heartburn Hot Flashes
- Cold Feet Cold Hands
- Problem Urinating Tension
- Depression Nervousness
- Upset Stomach Headaches
- Pins and Needles in Legs Pins and Needles in Arms

- Numbness in Fingers
- Fainting
- Stiff Neck
- Menstrual Irregularity
- Sleeping Problems
- Sensitivity to Light
- Diarrhea
- Ringing in Ears
- Loss of Smell
- Fatigue
- Irritability
- Broken Bones
- High/Low Blood Pressure
- Cancer
- Sinus
- Numbness in Toes
- Neck Pain
- Back Pain
- Menstrual Pain
- Loss of Balance
- Constipation
- Loss of Taste
- Buzzing in Ears
- Cold Sweats
- Fever
- Dizziness
- Arthritis
- Heart Condition
- Stroke

The statements made on this form are accurate to the best of my recollection, and I agree to allow Hornback Chiropractic & Wellness to examine me for further evaluation.

Signature _____

Date _____

H C W

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Lifestyle Questionnaire

- Exercise:**
- No exercise
 - Mild exercise (walking, stairs, yard work)
 - Medium exercise (less than 3x/week for 30 min)
 - Regular vigorous exercise (more than 4x/week for 30 minutes)

Energy Level: 0 (No energy) _____ 10 (High energy)

Eating Habits: How many meals do you eat a day? _____

Typical daily diet:
 Breakfast: _____
 Lunch: _____
 Dinner: _____

Do you have any digestive problems? How often and what type? _____

- Caffeine:**
- None
 - Coffee Tea Cola
 - # of cups/ cans per day _____

- Water:**
- None
 - 2-4 glasses
 - 4-8 glasses
 - > 8 glasses

Tobacco: Do you use tobacco? _____

Cigarettes-pks/day _____ Chew #/day _____ Pipe- #/day _____ Cigars-#/day
_____ # of years _____

Alcohol: Do you drink alcoholic beverages? _____

Socially 0-5 drinks per week 5+ per week

Sleeping: How many hours of sleep do you get in a typical night? _____

How many times do you wake up in the night? _____

What is your sleeping posture? Side Stomach Back

Surgeries: _____

Is stress a problem for you? Yes or No

Do you feel depressed? Yes or No

Do you have trouble focusing or paying attention? Yes or No

Are you as happy and as healthy as you want to be? Yes or No _____