Hill Valley
CHIROPRACTIC

Please Print Clearly

General Information

Patient: Last Name: _____ First Name: _____

Street Address: _____

City _____ State _____ Zip Code _____

Phone (_____)_____

Email Address: _____

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

Right handed ☐ Left handed ☐

Whom may we thank for referring you to us? _____

HEALTH HISTORY

Give reason for seeking chiropractic care: _____

_____

Are you under the care of any other doctor? Yes ☐ No ☐
If Yes, the conditions being treated for: _____

_____

List any current Medications: _____

List any past surgeries and dates: _____

List and past accidents and dates: _____

List any x-rays you've had in the past 2 years: _____

PERSONAL AND FAMILY HISTORY: Circle all that apply

Your Occupation: _____ Work Duties: _____

Significant for: Diabetes; Cancer; heart disease; Other: _____; unobtainable/adopted

Spouse's health status: _____

Children's ages and health status: _____

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? ☐ Yes ☐ No If Yes Doctor's Name _____

Date of last chiropractic visit: _____ Reason for care: _____

How long were you under care? _____

Are other family members under chiropractic care? ☐ Yes ☐ No Who? _____

SOCIAL HISTORY:

Current or history of drug use? ☐Yes ☐No If yes, please explain: _____

Current or history of alcohol use? ☐Yes ☐No Drinks per day _____ Year Quit _____

Current or history of tobacco use? ☐Yes ☐No Packs per day _____ Year Quit _____

Current or history of caffeine use? ☐Yes ☐No Drinks per day _____ Year Quit _____

Present living situation? ☐ Alone ☐ With spouse ☐ With Children ☐ With Parents ☐ With other: _____

Marital History? ☐ Married ☐ Divorced ☐ Widowed ☐ Single

WOMAN: Are you currently pregnant or plan on becoming pregnant? ☐ No ☐ Yes

INITIAL TREATMENT GOAL: What would you like to achieve from treatments? _____

_____

WELLNESS COMMITMENT

At Hill Valley Chiropractic, we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment towards obtaining and maintaining health and wellness.

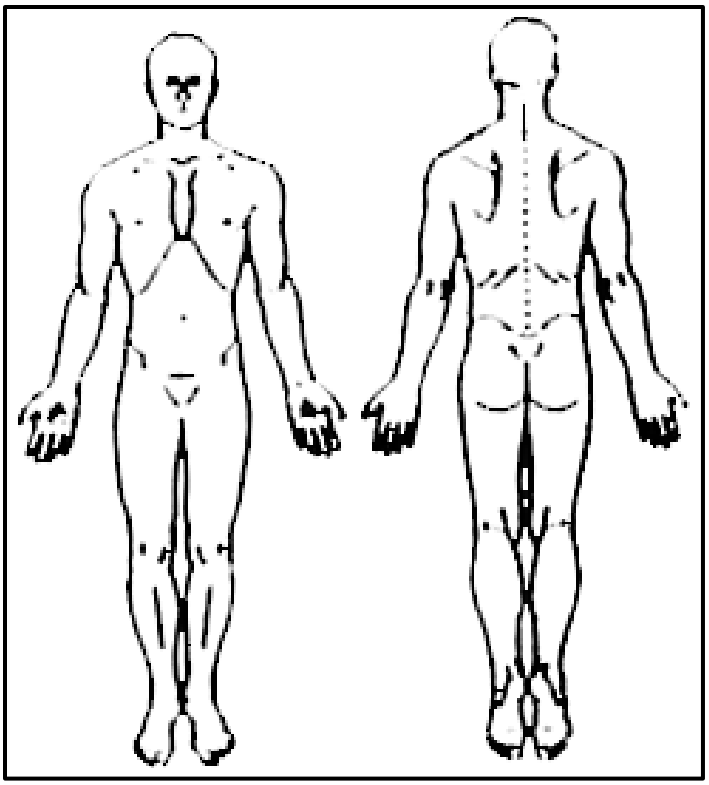
10%----------20%---------30%---------40%---------50%----------60%---------70%---------80%---------90%----------100%

Please circle interests in treatment options: chiropractic care, physical therapy, medications, injections, nutrition information

<u>Please Check</u> If you have had the following, or if you suffer from the following

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other joint pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problem	☐	☐
Nose Bleeds	☐	☐
Ringing in the Ears	☐	☐
Earaches	☐	☐
Cough	☐	☐
Chest Pains	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Digestive Problems	☐	☐
Urinary Problems	☐	☐
Skin Conditions	☐	☐
Other _____	☐	☐

Please circle the areas where you have any problems.



Please fill in any other health information you feel we might need for your care.

_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary healthcare services I may need.

Signature: _____

Date: _____