HANSONCHIROPRACTIC
Injury Care Massage Therapy

Name_____DOB___/___/___Age_____Today's Date___/___/___
Address _____ City_____ State_____ Zip_____
SSN:_____-____-_____ Driver's License #_____ Sex: *Male* *Female* (circle one)
Home #( )_____Page/Cell #( )_____**ATT, Sprint, T-Mobile,** _____
Email_____Occupation_____
Employer's Name _____
Address: _____ *City*_____ *State*_____ *Zip*:_____
Single *Married* *Divorced* *Widowed* Name of Spouse _____
# of children_____ Names of children_____
Who can we thank for referring you to our office? _____

Was this injury a result of: ☐ Work Injury? ☐ Car Accident? ☐ Other Injury? (check one)

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT: As a chiropractic office that centers on family wellness, we focus on helping you reach your optimum health potential. Our first goal is to locate and eliminate any and all interference to reaching your maximum potential while addressing the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. We all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes when it's already too late! Your answers to the following questions will give us a general view of the stresses you have faced in your life. This will allow us to better assess your current status and more accurately determine your true health potential.

THE BEGINNING YEARS – 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.

BIRTH HISTORY – *Please check all that apply.*

☐ Mother smoked/drank/drugs during pregnancy ☐ Epidural/Med's in Labor ☐ Breech
☐ C-Section ☐ Forceps Delivery ☐ Vacuum Extractor Used ☐ Labor Induced
☐ Complications ☐ Other _____

CHILDHOOD YEARS (0-17 years) – *Please check all that apply.*

☐ Childhood illness ☐ Serious Falls ☐ Active in sports ☐ Very Inactive
☐ Car Accident(s) ☐ Surgery/Stitches ☐ Alcohol Abuse ☐ Smoker
☐ Antibiotics ☐ Drug Abuse ☐ OTC Medications ☐ Vaccinated
☐ Broken Bones ☐ Under Chiropractic Care ☐ Severe Emotional Trauma(s)_____

ADULT YEARS (Age 18 to Present) – *Please check all that apply.*

☐ Present Smoker ☐ Former Smoker ☐ OTC Medications ☐ Poor sleep
☐ Alcohol Use ☐ Play Sports ☐ Surgery/Stitches: yrs old? _____ ☐ Work Injury
☐ High Job Stress ☐ High Personal Stress ☐ Poor Diet ☐ Drive a lot
☐ Flat feet ☐ Prescription Medications ☐ Not Enough Sleep ☐ Broken Bones
☐ No Exercises ☐ Severe Health Problems ☐ Wear Orthotics/Lifts ☐ Sit a lot
☐ Car Accidents: _____ (yrs old?) ☐ *Other Injuries*:

_____

☐ Have been under chiropractic care in the past – How long ago was your last adjustment?_____

Please list all prescriptions you are currently taking: _____

Who is your Primary Care Physician? _____

Please list any allergies below (include allergies to oils/scents for massage)

_____

Are you currently pregnant? YES / NO Due date: _____

Do you have a history of any of the following?

☐ Work Injury ☐ Motor Vehicle Accident ☐ Slip and Fall Accident

If so, please list approximate dates and incidents of the injuries

Date: _____ Incident:_____
Date: _____ Incident:_____

Have you ever been hospitalized? Yes / No

Date: _____ Condition:_____
Date: _____ Condition:_____

Have you had any surgeries?
Date: _____ Condition:_____
Date: _____ Condition:_____

Review of Systems

Musculoskeletal Issues
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Scoliosis
- ❑ Neck Pain
- ❑ Back problems
- ❑ Hip disorders
- ❑ Knee injuries
- ❑ Foot/ankle pain
- ❑ Shoulder problems
- ❑ Elbow/wrist pain
- ❑ TMJ issues

Neurological Issues
- ❑ Anxiety
- ❑ Depression
- ❑ Memory issues
- ❑ Sleeping Issues
- ❑ Headache
- ❑ Dizziness
- ❑ Pins and needles
- ❑ Numbness
- ❑ Loss of smell or taste

Head and ENT Issues
- ❑ No update or change
- ❑ Changes in head dimensions
- ❑ Blurred or double vision
- ❑ Earache
- ❑ Ringing in the ears
- ❑ Chronic ear infections
- ❑ Hoarseness
- ❑ Sore Throat
- ❑ Difficulty Swallowing

Cardiovascular Issues
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Dizziness
- ❑ Hypertension
- ❑ Hypotension
- ❑ High Cholesterol
- ❑ Lower Extremity edema

Respiratory Issues
- ❑ Cough
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Pneumonia

Gastrointestinal Issues
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Pain
- ❑ Heartburn
- ❑ Ulcer
- ❑ Food Sensitivities
- ❑ Constipation
- ❑ Diarrhea

Endocrine Issues
- ❑ Diabetes
- ❑ Heat or cold intolerance
- ❑ Hyperthyroidism
- ❑ Pancreatic conditions

Genitourinary Issues
- ❑ Urgency
- ❑ Incontinence
- ❑ Blood in Urine

Dermatological Issues
- ❑ No dermatological complaints
- ❑ New rashes
- ❑ Easy bruising
- ❑ Gum bleeding
- ❑ Eczema
- ❑ Psoriasis
- ❑ Skin cancer

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. If the office accepts an assignment of benefits under any insurance plan, the Patient will remain primarily responsible for all bills and shall be obligated to pay any and all sums not actually paid by the insurance carrier. I agree to allow this office to examine me for further evaluation.

_____ ____/____/_____
Signature Date

Please list your pains complaints from most severe to least severe

Complaint #1

Did it start: Gradually or Suddenly

Today, you have the following physical complaints: _____

Is this complaint: ___ Sharp, ___ Dull, ___ Achy, ___ Throbbing, ___ Numb, ___ Electric/Shooting, ___Other

Does it radiate anywhere: Yes No If yes, Where: _____

How long have you had this complaint? #_____ Days, Weeks, Months, or Years (circle one)

How did this complaint begin: ___Auto Accident, ___Work Injury, ___Slip or fall, ___gradually over time, ___Unknown

What is the % of time you experience this complaint: ___ Intermittently (1 to 25%)
___ Occasionally (26 to 50%)
___ Frequent (51 to 75%)
___ Constantly (76 to 100%)

Is it getting ___Better, ___Worse, ___Same

On a scale of 1-10, Rate you discomfort **CURRENTLY**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

On a scale of 1-10, Rate you discomfort **AT ITS WORST**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

This complaint is having a negative impact on: ___Job, ___Caring for Children, ___Exercise,
___ Recreation Activities, ___ Sleep, ___ Household Chores, ___Self Care

What activities aggravate this complaint? ___Bending, ___Exercising, ___Repetitive motions, ___Sitting, ___Standing

What activities relieve this complaint? ___Stretching, ___Icing, ___Rest, ___Changing positions, ___Exercising

Complaint #2

Did it start: Gradually or Suddenly

Today, you have the following physical complaints: _____

Is this complaint: ___ Sharp, ___ Dull, ___ Achy, ___ Throbbing, ___ Numb, ___ Electric/Shooting, ___Other

Does it radiate anywhere: Yes No If yes, Where: _____

How long have you had this complaint? #_____ Days, Weeks, Months, or Years (circle one)

How did this complaint begin: ___Auto Accident, ___Work Injury, ___Slip or fall, ___gradually over time, ___Unknown

What is the % of time you experience this complaint: ___ Intermittently (1 to 25%)
___ Occasionally (26 to 50%)
___ Frequent (51 to 75%)
___ Constantly (76 to 100%)

Is it getting ___Better, ___Worse, ___Same

On a scale of 1-10, Rate you discomfort **CURRENTLY**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

On a scale of 1-10, Rate you discomfort **AT ITS WORST**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

This complaint is having a negative impact on: ___Job, ___Caring for Children, ___Exercise,
___ Recreation Activities, ___ Sleep, ___ Household Chores, ___Self Care

What activities aggravate this complaint? ___Bending, ___Exercising, ___Repetitive motions, ___Sitting, ___Standing

What activities relieve this complaint? ___Stretching, ___Icing, ___Rest, ___Changing positions, ___Exercising

Complaint #3

Did it start: Gradually or Suddenly

Today, you have the following physical complaints: _____

Is this complaint: ___ Sharp, ___ Dull, ___ Achy, ___ Throbbing, ___ Numb, ___ Electric/Shooting, ___Other

Does it radiate anywhere: Yes No If yes, Where: _____

How long have you had this complaint? #_____ Days, Weeks, Months, or Years (circle one)

How did this complaint begin: ___Auto Accident, ___Work Injury, ___Slip or fall, ___gradually over time, ___Unknown

What is the % of time you experience this complaint: ___ Intermittently (1 to 25%)
___ Occasionally (26 to 50%)
___ Frequent (51 to 75%)
___ Constantly (76 to 100%)

Is it getting ___Better, ___Worse, ___Same

On a scale of 1-10, Rate you discomfort **CURRENTLY**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

On a scale of 1-10, Rate you discomfort **AT ITS WORST**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

This complaint is having a negative impact on: ___Job, ___Caring for Children, ___Exercise,
___ Recreation Activities, ___ Sleep, ___ Household Chores, ___Self Care

What activities aggravate this complaint? ___Bending, ___Exercising, ___Repetitive motions, ___Sitting, ___Standing

What activities relieve this complaint? ___Stretching, ___Icing, ___Rest, ___Changing positions, ___Exercising

Complaint #4

Did it start: Gradually or Suddenly

Today, you have the following physical complaints: _____

Is this complaint: ___ Sharp, ___ Dull, ___ Achy, ___ Throbbing, ___ Numb, ___ Electric/Shooting, ___Other

Does it radiate anywhere: Yes No If yes, Where: _____

How long have you had this complaint? #_____ Days, Weeks, Months, or Years (circle one)

How did this complaint begin: ___Auto Accident, ___Work Injury, ___Slip or fall, ___gradually over time, ___Unknown

What is the % of time you experience this complaint: ___ Intermittently (1 to 25%)
___ Occasionally (26 to 50%)
___ Frequent (51 to 75%)
___ Constantly (76 to 100%)

Is it getting ___Better, ___Worse, ___Same

On a scale of 1-10, Rate you discomfort **CURRENTLY**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

On a scale of 1-10, Rate you discomfort **AT ITS WORST**: 1 2 3 4 5 6 7 8 9 10 (0= no discomfort, 10= Excruciating)

This complaint is having a negative impact on: ___Job, ___Caring for Children, ___Exercise,
___ Recreation Activities, ___ Sleep, ___ Household Chores, ___Self Care

What activities aggravate this complaint? ___Bending, ___Exercising, ___Repetitive motions, ___Sitting, ___Standing

What activities relieve this complaint? ___Stretching, ___Icing, ___Rest, ___Changing positions, ___Exercising

Over 70% of our patients bring their children in to get adjusted. If you would like to have your children and/or spouse checked for subluxations check the box below and they can receive a complimentary exam including any necessary X-rays within 2 weeks of you starting care. The exam is of no cost to you and does not obligate them to receive future care. Has your spouse complained of back, neck, or shoulder pain in the last 3 years? Bring them in for a free check.

- ❑ Yes, I would like my family members checked for subluxations in the next 2 weeks

Signature: _____ Date: _____