

PATIENT INFORMATION

Date: _____ E-mail address: _____
Name: _____ Referred By: _____
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
Birth Date: _____ Sex: _____ Age: _____ Marital Status: _____ # of Children: _____
Occupation: _____ Employment: _____ Work Phone #: _____
Social Security #: _____ Driver's License #: _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential)

MAJOR COMPLAINT: _____

How long have you had this condition? _____

Date began: _____ Have you lost work days: Yes () No () How many? _____

Have you had this similar condition before? Yes () No () When? _____

Was the injury related to: Work accident () Auto accident ()

When did you last see a Chiropractor? _____ Dr.: _____

Why did you see this Chiropractor? _____ Where you helped? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow it? _____ if not, why? _____

Why are you changing Chiropractors? _____

MARK THE PRESENT CONDITIONS BELOW WITH AN X AND THE PAST CONDITIONS WITH AN O.

- | | | |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Auto Accidents | <input type="checkbox"/> Mistake Sidedness (R. from L.) | <input type="checkbox"/> Heath Problems |
| (a) <input type="checkbox"/> 0-1 years ago | <input type="checkbox"/> Stutter | <input type="checkbox"/> Stroke |
| (b) <input type="checkbox"/> 1-5 years ago | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> High or Low Blood Pressure |
| (c) <input type="checkbox"/> More than 5 years ago | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Other Accidents/Falls | <input type="checkbox"/> Lose Temper Easily | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Knocked Unconscious | <input type="checkbox"/> Headache | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Neck Pain or Stiff R. L. | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Mental or Emotional Disorder | <input type="checkbox"/> Numbness, Tingling, or Pain in Arms,
Hands, Finger R. L. | <input type="checkbox"/> Excessive Gas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Jaw Pain or Click (T.M.J.) R.L. | <input type="checkbox"/> Belching/Bloating After Meals |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Seems to Heavy | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Swollen or Painful Joints | <input type="checkbox"/> Head & Shoulders Feel Tired | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Difficulty in Excessive (Standing,
Walking, Sitting, Riding, Bending,
Lifting, Twisting, Household Duties) | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Shoulder Pain R.L. | <input type="checkbox"/> Colon Trouble |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Ringing in Ears R.L. | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss R.L. | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent Cold/Flu | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Loss Balance | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Blurred or Double Vision R.L. | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Upper Back or Stiffness R.L. | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Mid Back or Stiffness R.L. | <input type="checkbox"/> Menstrual Problems/PMS |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Lower Back Pain or Stiffness R.L. | <input type="checkbox"/> Menopausal Problems |
| <input type="checkbox"/> Excess Sweating | <input type="checkbox"/> Numbness, Tingling or Pain in Buttocks,
Thighs, Legs, Feet, Toes R.L. | <input type="checkbox"/> Brest Lumps, Soreness,
Discharge |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Pain with Cough, Sneeze or Strain at Stools | <input type="checkbox"/> Pregnant (Now) |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Hip Pain R.L. | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Foot Trouble R.L. | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Light Headed Upon Rising | <input type="checkbox"/> Asthma | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Under Stress | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Crave Sweets or Salt | <input type="checkbox"/> Difficulty Breathing | _____ |
| <input type="checkbox"/> Eating Disorders | | _____ |
| <input type="checkbox"/> Trouble Sleeping | | _____ |
| <input type="checkbox"/> Trouble Concentrating | | _____ |
| <input type="checkbox"/> Loss Memory | | _____ |

WHAT IS HEALTH PHILOSOPHY? (What should you do to be healthy?) _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptoms but not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____

1. What are your favorite activities or hobbies to do now? _____
2. Are your current problems affecting these activities or hobbies? _____
3. What activities are you looking forward to do in retirement? _____
4. Who would you like to be doing these with? _____

On scale of 1 – 10 (10 being the most, and 1 being the least)

_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their maximum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription): _____

Name other doctors you have seen for this condition: what was done, and for how long? _____

Are you currently wearing: Heel Lifts () Arch Supports ()

PLEASE FEEL FREE TO DISCUSS OUR TREATMENTS, FEES AND CONTENT. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

WITH MY SIGNATURE BELOW I AGREE TO ALLOW THE DOCTOR TO EXAMINE / EVALUATE MY CONDITION(S) AND TO TREAT MY CONDITION(S) AS (S) HE DEEMS APPROPRIATE. This consent will remain valid for the duration of treatment and includes any emergency home visits.

The procedures include various forms of adjustments, manual therapy, spinal decompression, Class IV healing laser and diagnostic X-rays. All though rare, possible risks include, however are not limited to: fractures, disc injuries, strokes, dislocations, and sprains.

I understand that all information provided by me during the course of treatment will remain confidential.

Patient Signature _____ Date _____

Legal Guardian (if required) _____ Date _____

Witness Signature _____ Date _____

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