Date: _____

Castle Hills Chiropractic

Bringing Wellness to Our World

Name: Last 4 digits Social Security:	Sex: Male Female Marital Status: M S W D Date of Birth: Age:
Address: City: State: Zip:	Cell Phone Number:
Occupation: Employer:	Employer Address: Office Phone:
E-Mail:	Family Medical Doctor:
Spouse's Name and Occupation:	Referred by: please list person's name ○ Friend/Family ○ M.D. / D.C. ○ Internet/Add ○ Other (please explain)
Children's Name and Ages:	Hobbies:
Emergency Contact and Relationship to You: Phone:	
Have you had chiropractic care before? If so, when and by whom?	

Castle Hills Chiropractic focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible chiropractic care, we will need to discover any **stresses** that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting Castle Hills Chiropractic: ○ Wellness / Prevention Care - I wish to continue my chiropractic wellness care.

○ A current problem

Please describe your current problem, including the effect it has had on your life:

_____

_____

_____

_____

_____

Is this problem due to, circle all that apply: Auto Work Other: _____

When did your problem begin?_____(specific date of possible)

Have you seen other doctors for this condition? Yes No **Describe:** _____

Please describe the character of your pain, check all that apply:

Sharp/Stabbing Sharp/Dull Achy Dull Soreness Weakness

Throbbing/Gnawing Numbness Shooting Gripping/Constricting

Burning Tingling Other_____

How bad is your pain or ache?

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

How often are the complaints present?

○ Constant: 76-100% ○ Frequent: 51-75% ○ Occasional: 26-50% ○ Intermittent: 25% or less ○ Night Only

When is the pain or symptom worse?

○ When you wake up ○ During the day ○ After work ○ In the evening ○ After eating ○ While sleeping

What makes the problem worse?

○ Standing ○ Sitting ○ Lying ○ Bending ○ Lifting ○ Twisting ○ Other _____

Is there anything you can do to relieve the problem? ○ No ○ Yes **What have you tried:** _____

Since your problem began is the pain: ○ increasing ○ decreasing ○ not changing

Do you sleep on your: ○ Back ○ Stomach ○ Left Side ○ Right Side

Physical activity at work: ○ sitting more than 50% ○ Light manual labor ○ Heavy manual labor

General physical activity: ○ No regular exercise program ○ Light exercise program ○ Strenuous exercise program

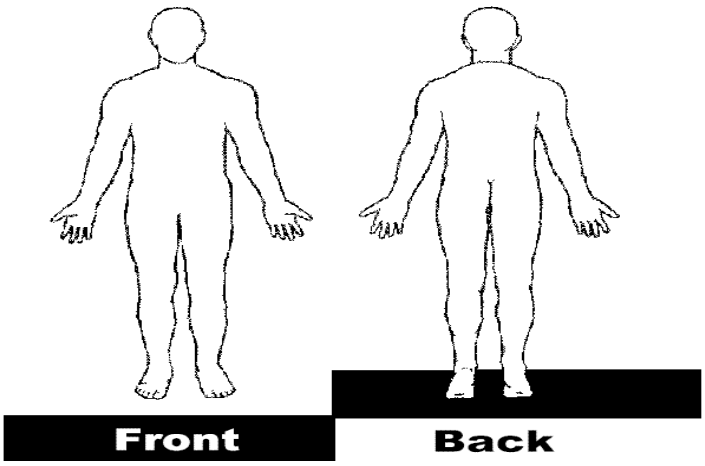
Rate your stress level: ○ No stress ○ Minimal stress ○ Moderate stress ○ Greatly stressed

Alcoholic beverages: ○ Yes ○ No **If yes, how many drinks per week? _____**

Draw on the diagram where you feel your symptoms

Use the letter to indicate the type and location of your pain or problem:

A = Ache B = Burning N = Numbness
S = Sharp T = Tingling P = Pins & Needles
O = Other



Do you currently smoke? Yes No

If YES, how many packs a day:_____

Number of years:_____

Female Patients ONLY:

Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

Date of Last Menses: _____ **My Menses is:** Regular Irregular

Are you currently taking an oral contraceptive (Birth Control Pill)? Yes No **If yes, for how long?** _____

Please include childbirth information (include dates, complications, etc): _____

_____

Describe any falls, auto accidents or major injuries - include month & year and type of accident:_____

_____

_____

Describe all past surgeries:_____

_____

List ALL medication that you are currently taking – prescription and over the counter:_____

_____

Personal History: Please circle all that apply:

Aneurysm	Broken/Fractured Bones	Epilepsy	Drug Addiction
Osteoporosis	Eating Disorders	Alcoholism	High/Low Blood Pressure
Diabetes	Ulcers	Coughing Blood	Seizures/Convulsions
Thyroid Disease	Pace Maker	HIV Positive	Hypertension
Arthritis	Cancer	Stroke	Excessive Bleeding
Congenital Disease	Gall Bladder Issues	Ruptures	Depression
Tuberculosis	Asthma	Mental Illness	Heart Condition

Family History: Please circle all that apply: Aneurysm Osteoporosis Diabetes Thyroid Disease Arthritis Cancer Stroke

Heart Condition Hypertension Asthma Other:_____

Father: Living Deceased Age is living: _____ **Mother:** Living Deceased Age is living: _____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem:

○ Headaches/Migraines	○ Buzzing/Ringing in Ears	○ Lungs	○ Low Back Pain
○ Dizziness	○ Fatigue	○ Heart	○ Hip Pain
○ Eyes/Vision	○ Fainting	○ Stomach	○ Leg Pain/Cramps
○ Concentration Loss	○ Sinus	○ Indigestion	○ Poor Circulation
○ Depression	○ Neck Pain/Stiffness	○ Bladder	○ Numb Felling
○ Nervousness	○ Feeling of Pins/Needles	○ Liver	○ Shoulder
○ Sleeping	○ Upper Back	○ Colon	○ Hot Flashes
○ Loss of Energy	○ Mid Back	○ Kidney	○ Cold Sweats
○ Tired Mornings	○ Chest Pain	○ Constipation	○ Diarrhea
○ Loss of Taste/Smell	○ Menstrual Pain/Irregularity	○ Urination	○ Fever

Please list all supplements and vitamins you take:_____

_____

How would you rate your health:

1 2 3 4 5 6 7 8 9 10

I have never felt worse — I feel great!

How committed are you to improving your health:

1 2 3 4 5 6 7 8 9 10

Not important — I want to be 100% healthy!

What is "being healthy" to you – check all that apply

○ Not being sick ○ Being symptom free ○ Having energy to do what I want, when I want

○ Not needing to take time off work ○ To fully enjoy all the aspects of life to the fullest extent possible

What is your goal or expectations with chiropractic care?_____

_____

I hereby authorize the doctor to examine and treat my condition as deemed appropriate through the use of chiropractic care and I give authority for these procedures to be performed. I have been informed of the financial policy and agree that I am responsible for all expenses incurred at Healing Source Chiropractic. I have had an opportunity to review the privacy policy and agree to its terms.

Patient Name (printed):_____

Patient Signature:_____ Date:_____