HOFFER CHIROPRACTIC P.C.

Full name:			**Date:**
Address: Street		City	State Zip
Home phone:		**Work phone:**	
Cell phone:		**Email address:**	
Best number/place to contact you:		**Emergency Contact:**	
Date of birth:	**Age:**	**Emergency Phone:**	
No. of children:		**Pregnant?** ☐ Yes ☐ No	
Height:		**Weight:**	
Marital Status: S M D W		**Soc Sec #:**	
Occupation:		**Spouse / Parent / Guardian name:**	
		Your Gender: **Male** ☐ **Female** ☐	

Who may we thank for referring you to our office? _____

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). **Please indicate the type of care that best meets your needs.**

□ **RELIEF CARE**
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

□ **CORRECTIVE CARE**
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but it optimizes function.

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = severe	% of the time pain is present	When did this episode start?	If you've had this condition before, when?	Did the problem begin with an injury?
1.					
2.					
3.					
4.					

Is your pain: □ dull □ sharp Do you have: □ numbness □ weakness Where? _____

Since the problem started is it: □ About the same? □ Getting better? □ Getting worse?

What makes it worse? _____ Better?_____

Doctors seen for this problem? □ None □ Chiropractor □ Medical Doctor □ Other_____

My condition interferes with: □ Work □ Sleep □ Sitting □ Walking □ Sports/Activity _____

Have you ever had: □ X-rays or □ MRI Of what area? _____

Do you currently wear orthotics or heel lifts? □ Yes □ No

Current Medicines: _____

Current Supplements: _____

Surgical Procedures: _____

I do (do not) have a family history of this or similar symptoms (Please explain): _____

_____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT APPLY

Past	Present		Past	Present	
□	□	Neck Pain	□	□	Loss of Bladder control
□	□	Shoulder Pain	□	□	Painful/Frequent Urination
□	□	Pain in upper arm/elbow	□	□	Frequent Nausea/Vomiting
□	□	Hand Pain	□	□	Constipation/Irregular bowel
□	□	Upper Back Pain	□	□	Difficulty swallowing
□	□	Low Back Pain	□	□	Heartburn/Indigestion
□	□	Leg Pain or Hip Pain	□	□	Tobacco use
□	□	Knee Pain	□	□	Alcohol use
□	□	Vision problems	□	□	Caffeine _____ cups/day
□	□	Dizziness	□	□	Excessive Thirst
□	□	Headaches	□	□	General Fatigue
□	□	Sinus Congestion/Allergies	□	□	Menstrual Cycle Dysfunction
□	□	Ear Aches	□	□	Prostrate/Sexual Dysfunction
□	□	Other: _____			

PLEASE INDICATE ANY OF THE FOLLOWING DISEASES

Past	Present		Past	Present	
□	□	Depression	□	□	Cancer
□	□	High Blood Pressure	□	□	Arthritis
□	□	Heart Attack	□	□	Diabetes
□	□	Stroke	□	□	HIV / AIDS
□	□	Asthma	□	□	Other:_____

Is there any other information that may help us to better understand you that has not been addressed?

_____

What was the compelling factor that brought you to this office at this point in time?

_____

I consent to a professional and complete chiropractic examination, any radiographic examination, physiotherapy, and chiropractic treatment that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. If patient is a minor (under 18) a parent or legal guardian must sign.

Signature: _____ Date: _____

Print Name: _____