HOFMANN
CHIROPRACTIC
CLINIC

#_____

Patient History

5000 Allen Road • Allen Park, MI 48101
Phone (313) 386-1050 • Fax (313) 386-2103

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ - _____ - _____ Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

Email Address: _____ Occupation: _____ Full/Part-Time/Unemployed

Date of Birth: _____ Social Security #: _____ - _____ - _____

Drivers License #: _____

Gender: ☐ M or ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W Children: ☐ Yes ☐ No How many? _____

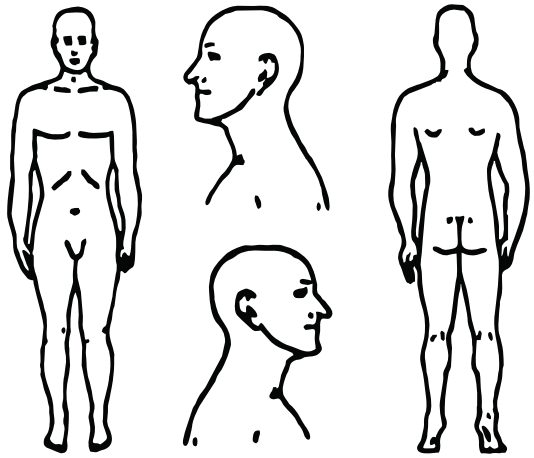
Ethnicity: ☐ Non-Hispanic or ☐ Hispanic

Preferred Language: ☐ English ☐ Spanish ☐ Other? _____

Race: ☐ White/Caucasian ☐ African American ☐ Native American ☐ Hawaiian/Pacific ☐ Asian
☐ Other _____

Referred by? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What are your **Primary Complaints?** _____

_____

_____

Check off any **Other Complaints** below that you experience on a regular basis:

☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Hip Pain ☐ Leg Pain ☐ Shoulder/Arm Pain ☐ Headaches

Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐ Yes ☐ No

How often do you experience your symptoms?

☐ Constant (76-100% of the day) ☐ Frequent (51-75% of the day)

☐ Intermittent (26-50% of the day) ☐ Occasional (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain ☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other _____

Please rate your pain on a scale of 1 to 10 (0=no pain and 10=excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect and 10=no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc.)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

Have you had recent treatment for this condition? ☐ No ☐ Yes

If yes, please explain: _____

Have you had any **Surgeries?** ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

List **ALL Past Medical History** conditions:

☐ Ankle Pain	☐ Elbow Pain	☐ High Blood Pressure	☐ Neck Pain
☐ Arm Pain	☐ Epilepsy	☐ Hip Pain	☐ Neurological Problems
☐ Arthritis	☐ Eye/Vision Problems	☐ HIV	☐ Pacemaker
☐ Asthma	☐ Fainting	☐ Jaw Pain	☐ Parkinson's
☐ Back Pain	☐ Fatigue	☐ Joint Stiffness	☐ Polio
☐ Broken Bones	☐ Foot Pain	☐ Knee Pain	☐ Prostate Problems
☐ Cancer	☐ Genetic Spinal Condition	☐ Leg Pain	☐ Shoulder Pain
☐ Chest Pain	☐ Hand Pain	☐ Menstrual Problems	☐ Significant Weight Change
☐ Depression	☐ Headaches	☐ Mid-Back Pain	☐ Spinal Cord Injury
☐ Diabetes	☐ Hearing Problems	☐ Minor Heart Problem	☐ Sprain/Strain
☐ Dizziness	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke/Heart Attack

☐ Other _____

Are you currently taking any **Medications?** ☐ No ☐ Yes

If yes, please list each medication (be specific) and what for? _____

_____

_____

Are you currently on anti-coagulant therapy (not including low dose aspirin)

or do you have any bleeding disorders? ☐ No ☐ Yes

Do you have any **Allergies?** (Drug or otherwise) ☐ No ☐ Yes

If yes, please list: _____

_____

_____

List your significant **Family History:** (Medical Conditions)

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Have you had any serious accidents? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

_____

Date of last physical examination: _____

Do you smoke? ☐ No ☐ Yes If yes, how much? _____

Have you ever smoked? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes If yes, how many per day? _____

Do you drink caffeine? ☐ No ☐ Yes If yes, how many per day? _____

Do you exercise? ☐ No ☐ Yes (what forms and how often) _____

_____

Have you ever had chiropractic care? ☐ No ☐ Yes

If yes, When? _____

Why? _____

Where? _____

Signature: _____ Date: _____

Print Name: _____

Parent/Guardian (if under age 18): _____