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 APPROPIATE 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.

___ Fractured Bones
___ Auto Accidents
(a) ___ 0-1 years ago
(b) ___ 1-5 years ago
(c) ___ More than 5 years ago
___ Other Accidents/Falls
___ Knocked Unconscious
___ Back Curvature
___ Mental or Emotional Disorder
___ Arthritis
___ Diabetes
___ Swollen or Painful Joints
___ Convulsions/Epilepsy
___ Skin Problems
___ Itching
___ Bruise Easily
___ Cancer
___ Frequent Cold/Flu
___ Nervous
___ Tension
___ Depressed
___ Irritable
___ Anemia
___ Excess Sweating
___ Tremors
___ Light Bothers Eyes
___ Allergy
___ Sinus Problems
___ Light Headed Upon Rising
___ Under Stress
___ Crave Sweets or Salt
___Eating Disorders
___ Trouble Sleeping
___ Trouble Concentrating
___ Loss Memory

___ Learning Disability
___ Mistake Sidedness (R. from L.)
___ Stutter
___ Dyslexia
___ Mood Changes
___ Lose Temper Easily
___ Headache
___ Neck Pain or Stiff R. L.
___ Numbness, Tingling, or Pain in Arms, Hands, Finger R. L.
___ Jaw Pain or Click (T.M.J.) R.L.
___ Head Seems to Heavy
___ Head & Shoulders Feel Tired
___ Difficulty in Excessive (Standing, Walking, Sitting, Riding, Bending, Lifting, Twisting, Household Duties)
___ Shoulder Pain R.L.
___ Dizziness
___ Ringing in Ears R.L.
___ Hearing Loss R.L.
___ Fainting
___ Loss Balance
___ Blurred or Double Vision R.L.
___ Upper Back or Stiffness R.L.
___ Mid Back or Stiffness R.L.
___ Lower Back Pain or Stiffness R.L.
___ Numbness, Tingling or Pain in Buttocks, Thighs, Legs, Feet, Toes R.L.
___ Pain with Cough, Sneeze or Strain at Stools
___ Hip Pain R.L.
___ Foot Trouble R.L.
___ Chest Pain
___ Asthma
___ Lung Problems
___ Difficulty Breathing

___ Wheezing
___ Heath Problems
___ Stroke
___ High or Low Blood Pressure
___ Varicose Veins
___ Liver Trouble
___ Gall Bladder Trouble
___ Digestive Problems
___ Excessive Gas
___ Belching/Bloating After Meals
___ Heartburn
___ Ulcers
___ Diarrhea/Constipation
___ Colon Trouble
___ Hemorrhoids
___ Prostate Problems
___ Impotence
___ Kidney Trouble
___ Kidney Stones
___ Frequent Urination
___ Discharge
___ Menstrual Problems/PMS
___ Menopausal Problems
___ Brest Lumps, Soreness, Discharge
___ Pregnant (Now)
___ Bedwetting
___ Ear Infection
___ Hepatitis
___ Venereal Disease
___ AIDS/HIV
_____
_____
_____
_____

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 YOU 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 APPROPIATE. 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_____

8280 Folsom Boulevard, Suite A, Sacramento, CA 95826
Office: 916.387.1007 Fax: 916.387.9843
drhulbert.com/sacramentochiropractor.com