**Hulsebus Chiropractic Clinic**

**1010 Harlem Road • Machesney Park, IL 61115**

**815.654.1044**

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Age) \_\_\_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_ /\_\_\_\_\_ Social Security #: \_\_\_\_\_ -\_\_\_\_\_ -\_\_\_\_\_\_\_ Marital Status: S M D W

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a Chiropractor before? Yes / No

**Purpose for This Visit**

Reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to an accident or specific injury (other than auto or work-related)\*? Yes / No If yes, when: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_

***\*If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk for the corresponding application.***

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.**

When did these symptoms begin? \_\_\_\_/\_\_\_\_ /\_\_\_\_\_ Are they: Constant Intermittent Activity-related

Are they getting worse? Yes / No Do they interfere with: Work Sleep Hobbies Daily Routine

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything that relieves your symptoms? Yes / No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced these symptoms before (if not accident/injury related)? Yes/ No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for this? Yes / No When were you last treated? \_\_\_\_/ \_\_\_\_ /\_\_\_\_

Who did you see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatment was performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you respond? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health & Lifestyle**

Do you exercise? Yes / No How often? \_\_\_\_\_ day(s) per week; Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities? Walking Running/Jogging Weight Training Cycling Yoga Pilates Swimming Other: \_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes / No How much? / How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes / No How much? / How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink coffee? Yes / No How much? / How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location

of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

B = BURNING

****P = PINS & NEEDLES

G = STABBING

M = SPASMS

F = STIFFNESS

N = NUMBNESS

T = TINGLING

**Health Conditions**

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.Please answer the following questions accurately so we may determine the full extent of your condition.

**CERVICAL SPINE (Neck)**

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

***Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.***

\_\_\_\_ Neck Pain \_\_\_\_ Headaches \_\_\_\_ Sinusitis

\_\_\_\_ Pain in shoulders/arms/hands \_\_\_\_ Dizziness \_\_\_\_ Allergies/Hay fever

\_\_\_\_ Numbness/tingling in arms/hands \_\_\_\_ Visual disturbances

\_\_\_\_ Hearing disturbances \_\_\_\_ Coldness in hands

\_\_\_\_ Weakness in grip \_\_\_\_ Thyroid conditions

**THORACIC SPINE**

Misalignment of the individual vertebrae or distortion of the upper thoracic curve originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

***Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.***

\_\_\_\_ Mid Back Pain \_\_\_\_ Heart Palpitations \_\_\_\_ Recurrent Lung Infections/Bronchitis

\_\_\_\_ Pain in Ribs/Chest \_\_\_\_ Heart Murmurs \_\_\_\_ Asthma/Wheezing

\_\_\_\_ Heartburn \_\_\_\_ Heart Attacks/Angina \_\_\_\_ Shortness of Breath

\_\_\_\_ Nausea \_\_\_\_ Diabetes \_\_\_\_ Ulcers

**LUMBAR SPINE (Low Back)**

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

***Please indicate (N) = Now, (P) = Past next to all conditions you’ve experienced or both if applicable.***

\_\_\_\_ Low back pain \_\_\_\_ Pain in hips/legs/feet \_\_\_\_ Weakness/injuries in hips/knees/ankles

\_\_\_\_ Numbness/tingling in legs/feet \_\_\_\_ Coldness in legs/feet \_\_\_\_ Muscle cramps in legs/feet

\_\_\_\_ Frequent/difficulty urinating \_\_\_\_ Constipation/Diarrhea \_\_\_\_ Menstrual irregularities/cramping

**OTHER**

Have you ever been hospitalized? Yes/ No

Please list any surgeries (include type of surgery and date it was performed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. Yes / No

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_