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: ____

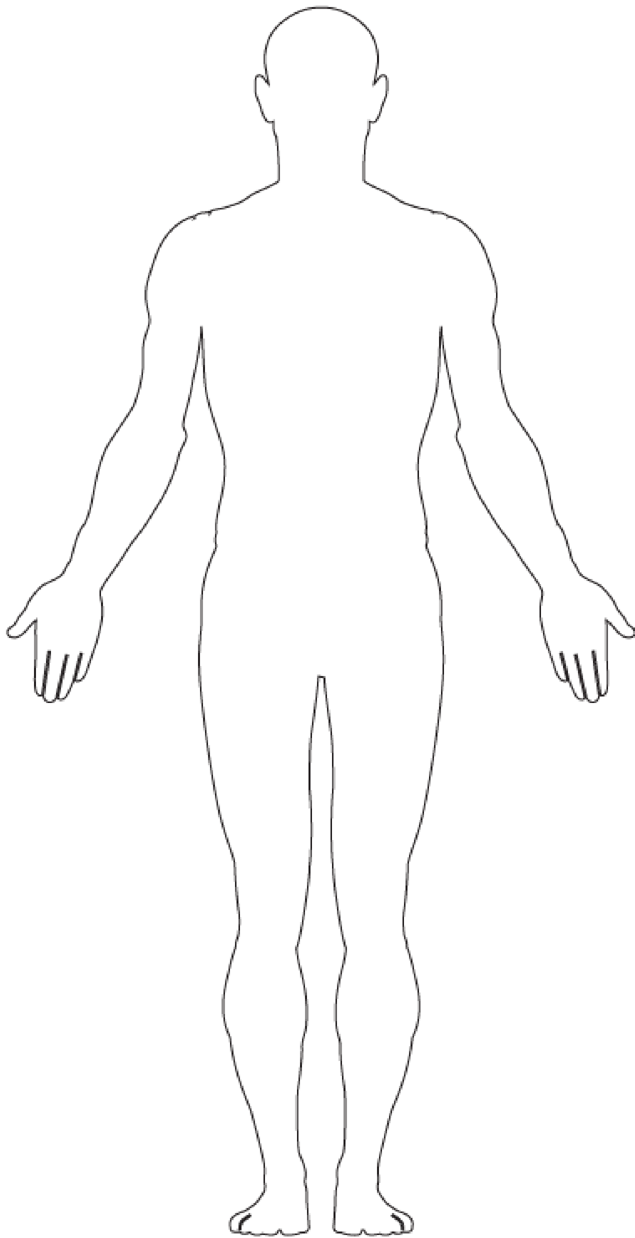
GENERAL SYMPTOMS CHART

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.

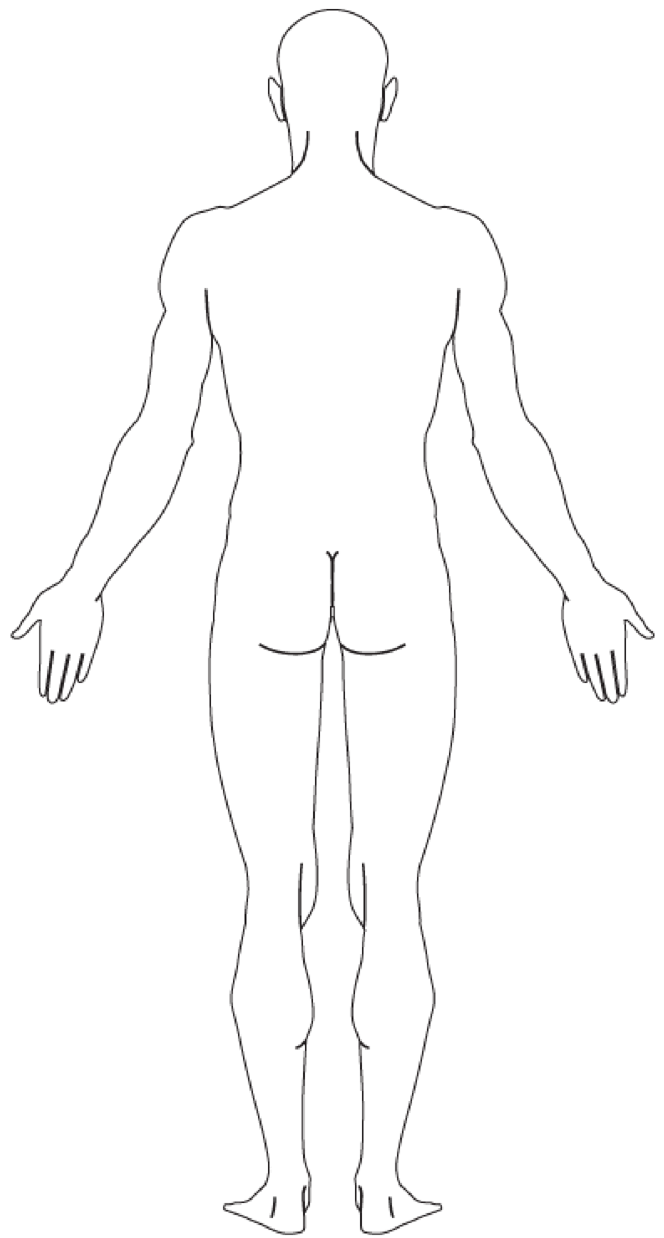
A = ACHE
B = BURNING
P = PINS & NEEDLES

G = STABBING
M = SPASMS
F = STIFFNESS

N = NUMBNESS
T = TINGLING



FRONT



BACK

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
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Sinusitis
____ Allergies/Hay fever

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
____ Pain in Ribs/Chest
____ Heartburn
____ Nausea
____ Heart Palpitations
____ Heart Murmurs
____ Heart Attacks/Angina
____ Diabetes
____ Recurrent Lung Infections/Bronchitis
____ Asthma/Wheezing
____ Shortness of Breath
____ 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
____ Numbness/tingling in legs/feet
____ Frequent/difficulty urinating
____ Pain in hips/legs/feet
____ Coldness in legs/feet
____ Constipation/Diarrhea
____ Weakness/injuries in hips/knees/ankles
____ Muscle cramps in legs/feet
____ 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# ______________________