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 **If your symptoms are the result of an auto accident or work-related injury, please see the front-desk.*

Reason for this visit: _____

Describe: _____

When did these symptoms begin? ____/____ /_____ How did your symptoms start? _____

Are they getting worse? Yes / No Are they: Constant Intermittent Activity-related

Do they interfere with: Work Sleep Hobbies Daily Routine Pain Scale: _____ (0 being no pain-10 being worst pain)

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? _____

Have you experienced these symptoms before? 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

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) or Prescription Medications? Yes / No

If yes, please list: _____

_____

_____

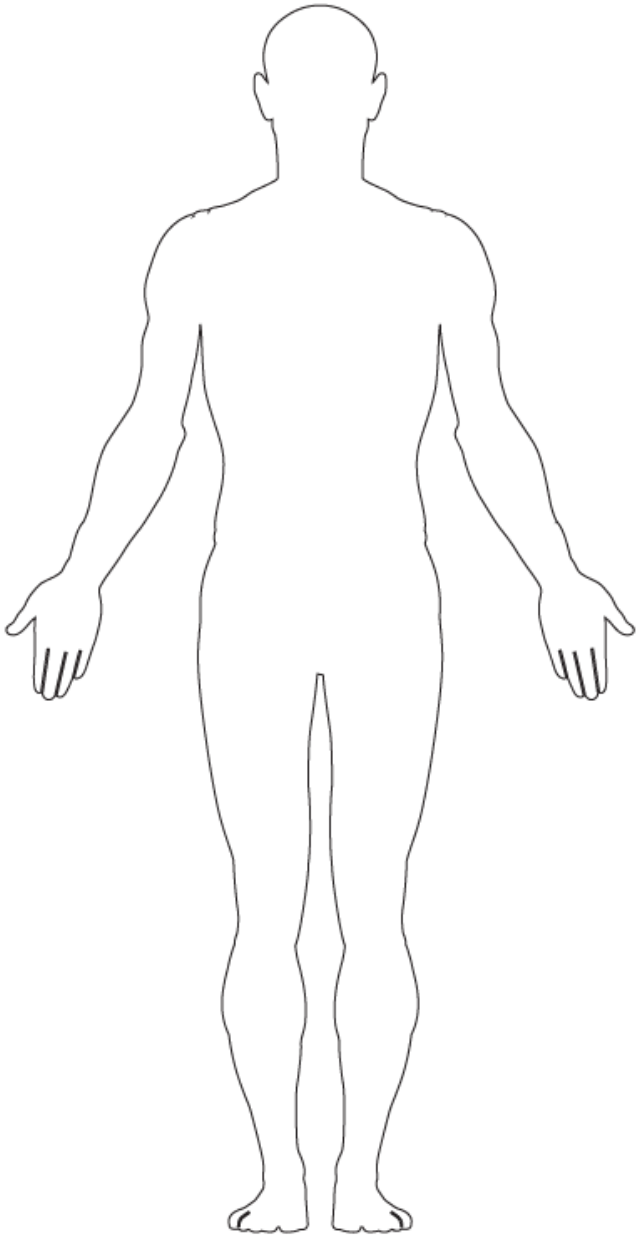
Are you allergic to any Medications? Yes / No If yes, please list: _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

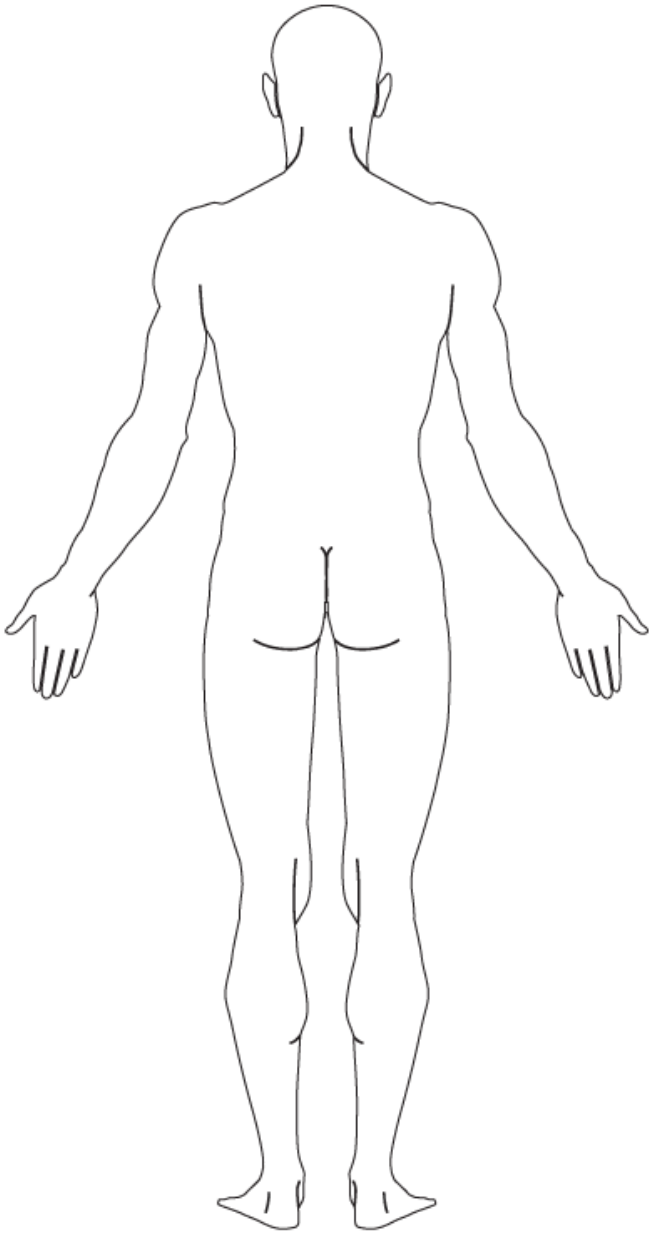
GENERAL SYMPTOMS CHART

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.

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

CERVICAL SPINE (Neck)

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

THORACIC SPINE

____ Mid-Back Pain
____ Pain in Ribs/Chest
____ Heartburn
____ Nausea
____ Heart Palpitations
____ Heart Murmurs
____ Heart Attacks/Angina
____ High Blood Pressure
____ Recurrent Lung Infections/Bronchitis
____ Asthma/Wheezing
____ Shortness of Breath
____ Diabetes

LUMBAR SPINE (Low Back)

____ Low back pain
____ Pain in legs/feet
____ Pain 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# _____