

HUDAK CHIROPRACTIC CLINIC, P.C.

804 Elm Street, St Joseph, MI 49085 ♦ (269) 983-5527

Patient Demographics and Health History

Today's Date

 /

Signature of Patient _____

Patient Title: *(check one)* Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

Which email address would you like us to use to communicate with you? *(check one)* Home Work

Contact Method *(check one)*

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth

 /

Age _____ Gender *(check one)* Male Female Unspecified

Whom may we thank for referring you? _____

Marital Status *(check one)* Single Married Other SSN _____

Spouse Name _____ Spouse D.O.B. _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____ Phone _____

EMPLOYMENT

Employment Status *(check one)*

Employed FT Student PT Student Other Retired Self Employed

Employer _____ Occupation _____

INSURANCE INFORMATION

Insurance Company _____ Policy Holder's Name _____

Relationship to Patient _____ Policy Holder's Employer _____

Policy Holder's Date of Birth _____ Policy Holder's SSN _____

Member/Subscriber ID Number _____ Group Number _____

HEALTH STATUS

Reason for Visit _____

Mark an X on the picture where you continue to have pain, numbness, etc.

Rate the severity of your pain. 0 (no pain) to 10 (severe pain).

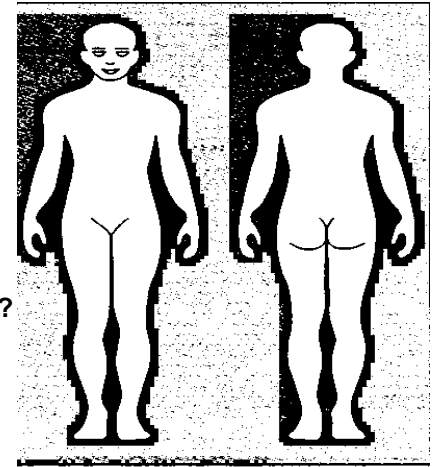
- 0 1 2 3 4 5 6 7 8 9 10

What caused the injury/pain? _____

Date your symptoms appeared? _____ OR has this been a gradual onset?

How frequent is your pain? _____

Is your pain worse/better/same in the morning/afternoon/evening?



Radiating pain on the Left Right Bilateral

- Pain Radiating to: shoulder upper arm arm arm to hand buttocks upper leg leg leg down to knee leg to foot

- Type of pain: Dull Sharp Sharp with Movement Throbbing Burning Deep Aching Tingling Stabbing Cramping Pinprick Numbness Radiating

- Aggravating Factors: Sitting Standing Walking Bending Stooping Lifting Sleeping Sneezing Coughing Straining Reaching Twisting Looking Up Looking Down Movement Resting Lying Supine Driving Typing Scooping Household Chores Exercise Stairs

- Relieving Factors: Sitting Standing Lying Down Knees Bent Up Leaning Against Support No Movement Movement Applying Heat Applying Ice Applying Topical Analgesic Taking Ibuprofen Taking Pain Medication Resting Stretching/Exercising Getting Adjusted

What treatments have you received for your condition? Medications Surgery Physical Therapy Chiropractic Services None Other _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Spinal Exam _____
Chest X-Ray _____ Blood Test _____ Urine Test _____
Dental Exam/X-Ray _____ MRI, CT Scan, Bone Scan _____

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

Injuries/Surgeries	Description	Date
Injuries	_____	_____
Surgeries	_____	_____
Auto Accidents	_____	_____
Work Accidents	_____	_____

Exercise	Work Activity	Habits
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Alcohol Drinks/Week _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Coffee/Caffeine Cups/Day _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High Stress Level Reason _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
No interest Very Interested

HEALTH STATUS continued

Briefly list your current main health problems/diagnoses: _____

Briefly list any previous health problems/diagnoses: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Are you pregnant? Yes No DUE DATE _____

MEDICATIONS

Current medications, including dosage if known.

If there are no current medications, check here:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Please list any vitamins, herbs, and/or minerals.

1) _____ 5) _____

2) _____ 6) _____

ALLERGIES

List any known allergies you have had to any medications.

If no allergies are known, check here:

1) _____ 3) _____

2) _____ 4) _____

List any other known allergies.

If no allergies are known, check here:

1) _____ 3) _____

2) _____ 4) _____

SIGNIFICANT FAMILY HISTORY

Mother: _____ Father: _____

Siblings: _____ Children: _____

Grandparents: (Maternal) _____ (Paternal): _____

Race (check one)

- White Black/African American Hispanic American Indian/Alaskan Native
- Asian Asian Indian Chinese Filipino
- Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
- Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

- English Spanish American Sign Language Chinese French German
- Tagalog Vietnamese Italian Korean Russian Polish
- Arabic Portuguese Japanese French Creole Greek Hindi
- Persian Urdu Gujarati Armenian I choose not to specify

Verification Question (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
- What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
- What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen question: _____
answer must be six letters or longer

Performed by Staff: Height: _____ inches **Weight:** _____ pounds **BP:** _____ / _____