NEW PATIENT INTAKE & HISTORY

Hoard Chiropractic
678 E XY Ave Vicksburg MI 49097
Dr. Kevin Hoard

PATIENT INFORMATION

Date _____ Name _____
(First name) (Last Name) (Middle Initial)
Address _____ City _____ State _____ Zip _____
Home Phone (___)_____ Cell (___)_____ E-mail _____
Sex: ☐ M ☐ F Date of Birth ____/____/_____ Age _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor
Spouse's name _____ Spouse's phone number (_____)_____
Number of children _____ Is there any possibility of pregnancy? ☐ Yes ☐ No If yes, due date? _____
Can we send appointment reminders to your phone? ☐ Yes ☐ No
Please check which reminder you prefer: ☐ Text 1 day before ☐ Text 2 days before ☐ Voice reminder ☐ No reminder
Occupation _____ Employer _____
Referred by _____ Have you ever had chiropractic care? ☐ Yes ☐ No
If yes, where/when were you last treated? _____
List any other immediate family members that are already patients here _____

ACCIDENT/INJURY INFORMATION

Is condition due to an accident? ☐ Yes ☐ No
Date of accident _____
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other
Have you been in an auto accident?
☐ Never ☐ Past year ☐ Less than 5 years ☐ Over 5 years
Have you had any of the following personal injuries?
☐ Head injury Date_____
☐ Broken bone Date _____
☐ Knocked unconscious Date _____
☐ Falls Date _____
Please inform receptionist if you are planning to bill Auto or if this is a Worker's Comp case

INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No
Is this insurance through your employer? ☐ Yes ☐ No
Who's responsible for this account?_____
Insurance Company _____ _____
Primary on Insurance _____
Relationship to Patient_____
Primary SS# _____
Primary Date of Birth _____
Primary Employer_____
Subscriber ID #_____
Group # _____

HABITS

Alcohol	☐ Light	☐ Moderate	☐ Heavy	☐ None
Tobacco	☐ Light	☐ Moderate	☐ Heavy	☐ None
Caffeine	☐ Light	☐ Moderate	☐ Heavy	☐ None
Exercise	☐ Light	☐ Moderate	☐ Heavy	☐ None
Sleep	☐ Light	☐ Moderate	☐ Heavy	☐ None

SURGERIES

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

MEDICATIONS

_____
_____
_____
_____
_____

SUPPLEMENTS

_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

HEALTH & ILLNESS HISTORY

Please check the appropriate box if you've experienced any symptoms in the past or if you are currently experiencing the symptom .

PAST CURRENT

General
- ☐ ☐ Convulsions
- ☐ ☐ Allergy
- ☐ ☐ Dizziness
- ☐ ☐ Fainting
- ☐ ☐ Headache
- ☐ ☐ Numbness

Conditions
- ☐ ☐ Alcoholism
- ☐ ☐ Anemia
- ☐ ☐ Appendicitis
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Eczema
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy
- ☐ ☐ Goiter
- ☐ ☐ Gout
- ☐ ☐ Heart Disease
- ☐ ☐ Multiple sclerosis
- ☐ ☐ Polio
- ☐ ☐ Rheumatic fever
- ☐ ☐ Stroke
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers

Muscle & Joint
- ☐ ☐ Arthritis
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between shoulders

Pain or numbness in:
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Gastrointestinal
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digestion
- ☐ ☐ Distention of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Abdominal pain
- ☐ ☐ Blood in stool
- ☐ ☐ Decreased appetite
- ☐ ☐ Ulcers

Neurological
- ☐ ☐ Stroke
- ☐ ☐ Seizures
- ☐ ☐ Head Injury
- ☐ ☐ Carpal tunnel
- ☐ ☐ Vertigo

Eyes, Ears, Nose, & throat
- ☐ ☐ Asthma
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ringing in ears
- ☐ ☐ Eye pain
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

Cardiovascular
- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Irregular heart beat
- ☐ ☐ Swelling of ankles
- ☐ ☐ Chest pain
- ☐ ☐ Heart attack
- ☐ ☐ Heart disease
- ☐ ☐ Aneurysm

Respiratory
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficulty breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

Skin
- ☐ ☐ Bruise easily
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

Genito-urinary
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Kidney infection
- ☐ ☐ Kidney stones
- ☐ ☐ Painful urination

For Women Only
- ☐ ☐ Excessive cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Miscarriage

HEALTH HISTORY CONT.

Please describe major complaint and symptoms

_____

_____

_____

Date you first noticed symptoms _____

Has this happened before? If so, when? _____

How did it start? ☐ Sudden onset ☐ Gradual onset ☐ Unsure

Since the onset, has it: ☐ Gotten worse ☐ Gotten better ☐ Stayed the same

Does your condition interfere with? ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation ☐ None

Do you have difficulty doing any of the following: ☐ Lifting ☐ Walking ☐ Bending ☐ Sitting ☐ Standing ☐ None

Does anything make the pain worse? _____

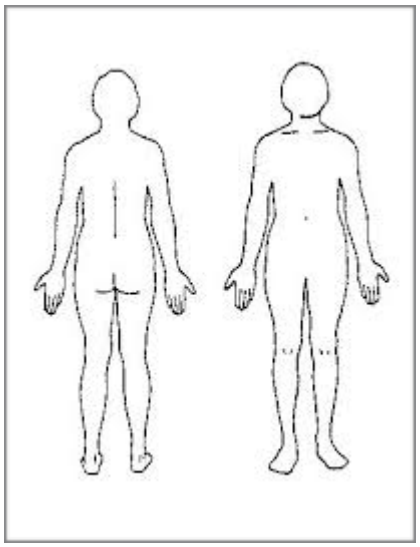
How would you rate your pain/symptoms on a scale of 1 (being no pain) to 10 (being the worst pain)?

0 1 2 3 4 5 6 7 8 9 10

No Symptoms — Worst Possible Pain

Please put an X on the diagram in the area where you are having pain or other symptoms. Check all that apply.

- ☐ Numbness
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Tingling
- ☐ Dull Ache
- ☐ Cramping
- ☐ Swelling
- ☐ Burning
- ☐ Throbbing
- ☐ Stiffness
- ☐ Radiating



Any additional information the doctor should be made aware of:

_____

_____

_____

_____

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate to the best of your ability and that you have read the case history questions entirely.

Signature _____ **Date** _____