



# Horton Chiropractic

Diagnosis and Treatment Using Innovative Technology and A Human Touch.

## Welcome!

To ensure your visit to Horton Chiropractic is a pleasant one, here is what you can expect during the next 30-60 minutes.

Paperwork	Complete this brief questionnaire and health history form to help us get to know you. The Doctor will use this information to help formulate the recommendations for your care.
Consultation	You will meet the Doctor. The Doctor will review your history and determine if yours is a Chiropractic case. You will be informed of the cost of any office procedures before they are being performed.
Examination	Thorough physical, orthopedic, neurologic, and chiropractic tests will be performed to determine the cause(s) of your presenting complaint. Computerized diagnostic testing will also be performed.
Imaging	Necessary views may be taken to visualize the location of any problems, neurologic interferences, reveal any pathology, and make your chiropractic care more precise
Correlation	Before proper care can rendered, the Doctor will study your examination findings. Later you will see your x-rays, review your findings, and receive specific care and recommendations from the Doctor.

## CONFIDENTIAL HISTORY QUESTIONNIERE

Full Name: \_\_\_\_\_ Email Address: \_\_\_\_\_ Date: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Name of Spouse/Significant Other (if applicable): \_\_\_\_\_ # of Children & Ages: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Emergency Name & Number: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Mobile Phone #: \_\_\_\_\_  
 How may we best reach you?  Home Phone  Work Phone  Mobile Phone  Email

### Insurance Information:

Insured's Name \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_

How did you hear about Horton Chiropractic? If someone referred you, what is their name? \_\_\_\_\_

## YOUR HEALTH PROFILE

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are first to address the issues that brought you into the office, and second, to offer you the opportunity for improved health potential and wellness services in the future. On a daily basis, we experience physical, chemical, and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

HABITS	EXERCISE	FAMILY HISTORY				
		Diabetes	Heart	Kidney	Cancer	Other
<input type="checkbox"/> Smoking Packs/Day: _____	<input type="checkbox"/> None					
<input type="checkbox"/> Drinking Alcohol: _____	<input type="checkbox"/> Light Activity					
<input type="checkbox"/> Caffeine Cups/Day: _____	<input type="checkbox"/> Moderate Activity					
	<input type="checkbox"/> Active					
	<input type="checkbox"/> Very Active					
	<input type="checkbox"/> Elite Athlete					
		Mother				
		Father				
		Brother, # of _____				
		Sister, # of _____				

## LIST OF CURRENT PROBLEMS

Chief Complaint: 1. \_\_\_\_\_ Duration (How Long): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 2. \_\_\_\_\_ Duration (How Long): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_  
 3. \_\_\_\_\_ Duration (How Long): \_\_\_\_\_ Previous Episodes: \_\_\_\_\_

## CHIEF COMPLAINT / PRESENT ILLNESS

Please briefly describe your area of chief complaint, including the effect it has had on your life. \_\_\_\_\_

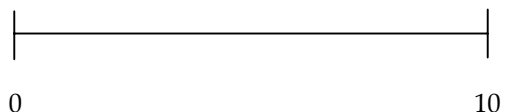
\_\_\_\_\_

\_\_\_\_\_

### VISUAL ANALOG SCALE

**Use the line to rate the intensity of your pain today.**

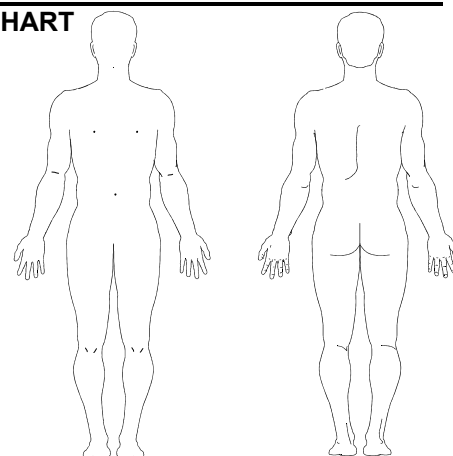
0= No Pain    10 = Most Intense ever felt



### PAIN CHART

Please mark area & type of pain on the drawings using the codes listed below.

N = Numbness  
 P = Pins & Needles  
 B = Burning  
 A = Aching  
 S = Stabbing



### CHECK ALL THAT APPLY

- If you are experiencing pain, it is...     Sharp     Dull     Comes & Goes     Travels     Constant  
 Since the problem started it is...     About the Same     Getting Better     Getting Worse  
 Yes, it interferes with:     Work     Sleep     Walking     Sitting     Hobbies     Leisure  
 What makes it worse? \_\_\_\_\_

Other Doctors seen for this problem (please list):

Chiropractors \_\_\_\_\_  
 Medical Doctors \_\_\_\_\_  
 Others \_\_\_\_\_

Please check (X) all of the symptoms you have ever had, even if they do not seem related to your current problem.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headache               | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Neck Pain            |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Loss of Balance      |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Ringing in Ears    | <input type="checkbox"/> Nervousness          |
| <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> Stomach Upset        |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Depression             | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Tension              |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Neck Stiffness         | <input type="checkbox"/> Cold Hands         | <input type="checkbox"/> Cold Feet            |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Hot Flashes          |
| <input type="checkbox"/> Cold Sweats            | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Menstrual Irritability | <input type="checkbox"/> Menstrual Pain         | <input type="checkbox"/> Mood Swings        | <input type="checkbox"/> Sensitivity to Light |

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that I am ultimately responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment to benefits. I authorize the use of this signature for insurance submissions. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate though the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnoses.

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_