**What is your Primary Health Goal?**

**Current Health Conditions, Medications, and Allergies**

What has brought you to into our office today?

What have you done for this up until now?:

□ No medications

List of Current Medications:

(if more than 6 give a list to the front desk)

Known Allergies:

□ I have no known allergies to medications

**Confidential Patient Information**

First Name: Last Name:

DOB: / / □ Male □ Female Occupation:

Email: Cell#: Home#:

Address: City: State: Zip:

Marital Status: # of Children: SS#:

Who referred you to Huffer Chiropractic:

Name of your last chiropractor: Date of last adjustment: / /



**Doctor’s History Form**

*(this page is for doctor’s use only)*

Date:

Name:

**Other Adjustements:**

**Cervical:** Occiput C1 C2 C3 C4 C5 C6 C7

Tenderness: R L B Hypertonicity: R L B Spasm: R L B Edema: R L B

□ Basic BEST

(C2-L5)

**ROM:** Mild

Moderate

Severe

Reduced in all ranges

**Thoracic:** T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

□ Rope

Physiology

(Thor-L1)

Tenderness: R L B Hypertonicity: R L B Spasm: R L B Edema: R L B

**ROM:** Mild Moderate

Severe

Reduced in all ranges

**Lumbar:** L1 L2 L3 L4 L5

Tenderness: R L B Hypertonicity: R L B Spasm: R L B Edema: R L B

**ROM:** Mild

Moderate

Severe

Reduced in all ranges

**Sacrum:** AI-R AI-L Base Posterior SAR SAL

Tenderness: R L B Hypertonicity: R L B

Spasm: R L B Edema: R L B

Reduced in all ranges

**ROM:** Mild

Moderate

Severe

**Pelvis:** R Ilium L Ilium

Tenderness: R L B Hypertonicity: R L B

Spasm: R L B

Edema: R L B

**ROM:** Mild

Moderate

Severe

Reduced in all ranges

**Goals:**

**Diagnosis**:

**Secondary DX:**

walking standing lifting sitting sleeping chores Other: Current Ability:

Where they

would like to be:

**Recommendations:**

Case Started: / / # of Follow-ups:

* New Case
* Follow-up # of visits thus far:
* Final visits per week for the next \_ weeks
* Cervical
* Thoracic
* Lumbar
* Sacral
* Pelvic

Cervicalgia Headache Brachial Plexus Pain Backache Spondylolysis Lumbago Radiculopathy

Spinal Instability Sciatica

Pain R Pain L Dysfunction

□ Other:

**Symptoms :**

**Case History:**

What were you doing when you noticed this happening? (Incident):

When did this latest incident occur? (date of onset):

What is this keeping you from doing, now, that you could do before the problem started? (repeat back their goals for care):

Complaint #1:

Level 1-10:

How often (freq): Description of problem: Intensity:

Complaint #2:

Level 1-10:

How often (freq): Description of problem: Intensity:

Complaint #3:

Level 1-10: How often (freq): Description of problem:

Intensity: