1404 Rice Rd., Ste. 400 Tyler, TX 75703
Ph. (903) 581-4393 FX: (903) 581-8511

HOPSON CHIROPRACTIC

Today's Date_____

Name _____ Birth date _____ Age_____ Gender ❑ M ❑ F
Address _____ City _____ State _____ Zip _____
Preferred Name_____Mom's Name _____Dad's Name _____
Mom's Phone_____Dad's Phone_____Home Phone_____
Mom's Employer_____Mom's Occupation_____
Dad's Employer_____Dad's Occupation_____
Name of Medical Doctor(s)_____
e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes
Emergency Contact _____ ph # _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Hopson Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____
Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

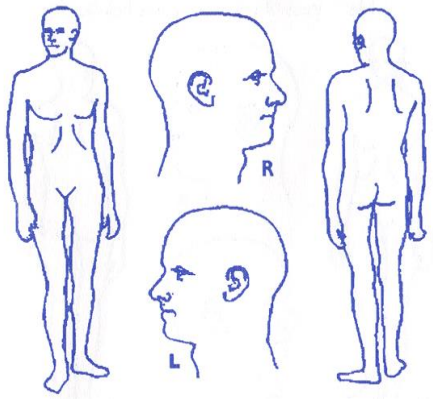
PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
2. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
3. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____
4. _____ How long has this been an issue? _____
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
   _____
6. What makes it better?_____
7. What makes it worse? _____
8. What Doctor's have you seen for this?_____
   _____
9. Type of treatment:_____
10. Results: _____
NOTES: _____
_____
_____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



ONE LIFE WELLNESS

1404 Rice Rd., Ste. 400 Tyler, Tx. 75703
Ph: (903) 581-4393 FX: (903) 581-5811

GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. List any medications being taken:_____
2. Number of courses of Antibiotics child has taken in the last 6 mo._____ Total during lifetime_____
3. Name of Pediatrician and Other Doctors: _____
4. Date of Last Visit _____/_____/_____ Reason:_____
5. Name of Obstetrician/Midwife:_____
6. Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home
7. Complications During Pregnancy: ❑ No ❑ Yes Explain:_____
8. Ultrasounds During Pregnancy: ❑ No ❑ Yes How Many:_____
9. Medication During Pregnancy / Delivery ❑ No ❑ Yes List:_____
10. Cigarette / Alcohol Use during Pregnancy: ❑ No ❑ Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ": ❑ No ❑ Yes, Name_____

PAST HISTORY

12. List any past auto collisions:_____ Was any care received?_____
13. List any past falls bumps bruises: _____ Was any care received?_____
14. List any past sport, recreational, or home injuries:_____
15. Please describe any past conditions and treatment received: _____

_____

16. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____