

Huffman Chiropractic

P.O. Box 9 (26 West Depot Street), Pataskala, OH 43062
740-927-9222

Legal Name _____ Spouse or SO _____

Prefer to be called _____ Birthdate _____ Age _____

E-mail _____ Do you have Medicare? Y N

Mailing Address _____

Phone number(s) _____ mobile home work

How did you hear about Huffman Chiropractic? _____

Huffman Chiropractic is a cash practice. Is your visit today due to an accident? Yes No

Is your visit today due to an injury at work? Yes No

What brings you to our office today?

Have you ever had this problem or pain before? Yes No If yes, when?

How was the last episode resolved?

When did your symptoms with the most recent episode first begin?

What do you think caused this situation?

What makes you feel better?

What makes symptoms worse?

What is harder to do because of how you feel? Family Chores Sleep Hobbies Work
Occupation _____

Are the symptoms: getting better staying the same getting worse

How do symptoms change over the course of the day (better in the morning or evening, for example).

What other treatments have you tried?

Have you had a bad chiropractic experience in the past?

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What do you hope to get out of treatment today?

Have you ever broken a bone? Y N If yes, where?

Do you have any pins, plates, or implants in your body? Y N

Have you ever had cancer? Y N Had chemotherapy? Y N Had radiation? Y N

Do you bruise easily? Y N Are you on a blood thinner? Y N

What allergies do you have? _____

Who is your family doctor? _____

Last visit? _____ Do you see any specialists? Y N

System review: Please circle any systems that cause you problems.

Blood/Blood vessels/Heart Breathing/Lungs Digestion

Eye Mouth/Teeth Ear/Nose/Throat/Sinuses Kidney/Bladder

Glands/Hormones Immune system Nervous System

Mental health Skin/Hair/Nails Bones/tendons/ligaments

Muscles Joints Genitals

Do you have:

- Y N Problems with recurring headaches?
- Y N Pain that wakes you from a sound sleep?
- Y N Unusual bleeding or discharge?
- Y N Any change in bowel or bladder habits/constipation/diarrhea?
- Y N An obvious change in a wart or mole?
- Y N A sore that will not heal?
- Y N A thickening or lump in the breast or elsewhere?
- Y N A nagging cough or hoarseness?
- Y N A drooping eyelid or change in your pupils?
- Y N Slurred speech or difficulty speaking?
- Y N Blood in your urine, stool or sputum?
- Y N Night sweats?
- Y N A recent episode of losing weight without trying?
- Y N Numbness on one side of your face or body?
- Y N Double vision, a loss of sight in one eye, visual disturbances, rapid eye movement?
- Y N Are you right-handed?

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Have you ever been diagnosed with a particular condition or disease? Please circle or list any diagnoses.

high blood pressure diabetes stroke aneurism COVID 19

Down's syndrome arthritis TB lupus anemia epilepsy

depression anxiety

Please list any diseases that run in your family.

L=Living D=Deceased (Please list approximate age & reason if deceased.)

Please list any health problems for these relatives. Include high blood pressure, heart attack or issues, emphysema, seizures, diabetes, asthma, stroke, thyroid disease, circulation problems, cancer.

Mom L D Maternal Grandma L D Maternal Grandpa L D

Dad L D Paternal Grandma L D Paternal Grandpa L D

Siblings:

Children:

List medications, herbs, supplements, and over the counter medications that you take.

What surgeries have you had? Please list approximate year with each.

Do you drink alcohol? Y N

Do you smoke or vape? Y N

Do you wear your seatbelt? Y N

Do you use marijuana, hemp, CBD, or recreational drugs? Y N

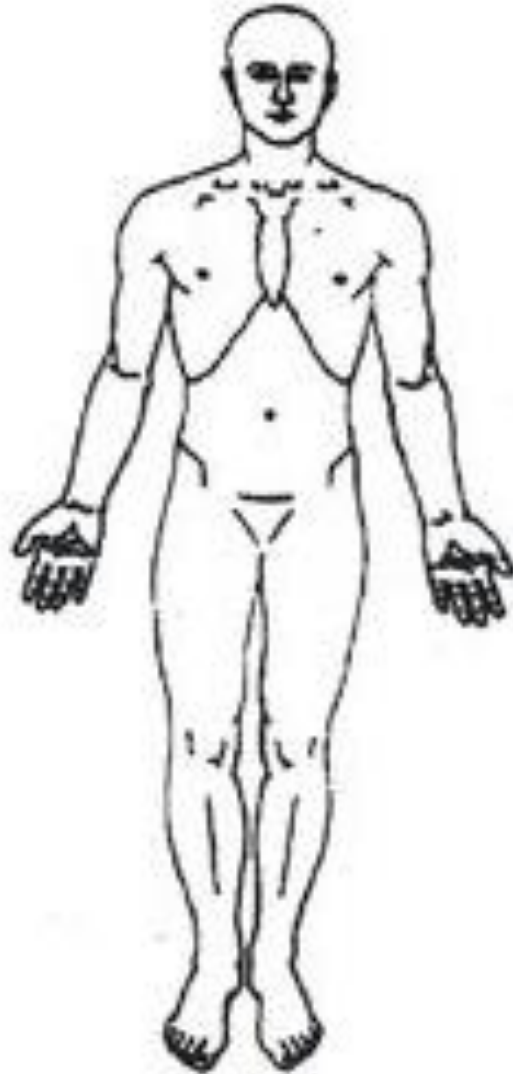
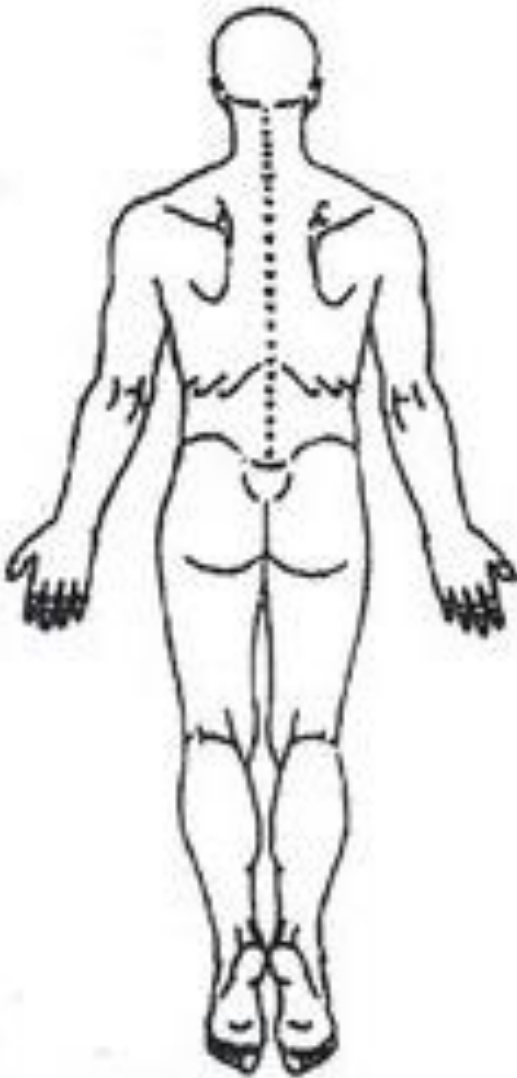
Are you safe in your home? Y N

Please list any other diseases, experiences, conditions, details, or information that we have not already requested which would help us give you the best care possible.

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Please mark on the diagram where you are experiencing symptoms. If you have symptoms in more than one location, please list them by priority (#1, #2, #3). Please also rate each location as 0 (no pain) to 10 (worst pain you can imagine).



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Please print this page and bring it with you to your appointment.
Do not initial or sign this form until you have spoken to the doctor.

- _____ I request services from T.A Huffman Inc., dba Huffman Chiropractic.
- _____ I am of sound mind and legally permitted to sign for my own care or the care of the minor who I am presenting to Huffman Chiropractic for care.
- _____ All of the information supplied by me on these forms is true and accurate to the best of my knowledge at the time I provided it. I have not intentionally omitted any information.
- _____ I acknowledge that I have read or had an opportunity to read a copy of Huffman Chiropractic's Notice of Privacy Practices.
- _____ The benefits, risks, and alternatives associated with chiropractic care have been explained to me. I have been given the opportunity to ask questions and to clarify anything I did not understand.
- _____ I understand that my pain may increase and that chiropractic care may not solve my problem(s). I have been made aware that there is a risk of suffering a variety of side effects with chiropractic adjustments including common ones like soreness and dizziness and rarer ones like cerebrovascular accident (stroke).
- _____ I have read and freely signed a copy of the Huffman Chiropractic financial agreement. I understand that **I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL FEES** associated with my care. I understand that Huffman Chiropractic will collect all fees **DIRECTLY FROM ME** in the form of cash, check, or money order at the time of service.

Huffman Chiropractic DOES NOT PARTICIPATE IN ANY INURANCE PLAN (although you are welcome to request a receipt or superbill and try to submit treatment costs yourself).

Huffman Chiropractic does not accept credit or debit cards at this time.

I agree to each term and condition above as evidenced by my initials before each statement.

Printed name

Signature

Witness

Date