Date:

Hill Country Holistic Health

CHIROPRACTIC INITIAL VISIT FORM

Name: ____

AGE: _________ Birth month _____________ Year__________

Phone: (______) _________ – _______________

Email :____

Address: ____

____

In Case of Emergency:
Contact ____
Phone: ( ) ________– ____________

Purpose of this appointment:____

When did this start: ________________________Have you seen any other Doctor for this condition: ( )Yes ( )No
Doctor & When:____

Have you been adjusted as a chiropractic patient previously? ☐ Nope ☐ I've heard great things and look forward to it
Referred by ____________________

☐ Yes, Dr. ______________________________________ ☐ Days ☐ months ☐ years ago.
For:_ ☐ Low back pain (LBP) ☐ Headaches ☐ Neck or upper back pain ☐ Other reason = ______________
Your experience with previous chiropractic was : ☐ Amazing ☐ OK ☐ Didn't help much

Have you been in a motor vehicle accident more than a minor fender bender? ☐ Nope, I'm lucky

☐ Yes, _____________ day / months / years ago.

☐ Car I was in was totaled
☐ Multiple cars involved
☐ Got banged up
☐ May have had whiplash
☐ May have been under influence of something

Other Details: ________________________________

____

If More than one MVA : ____

Surgeries? ☐ Spine ☐ Hip ☐ Knee ☐ Appendix ☐ Tonsils ☐ Gallbladder ☐ C-section
Where and when:
Detail / others:____

____

Any broken bones? ____
Where and when:

Any major Scars? ____
Where and when:

Any chronic conditions or inherited issues? ______________________________________

How are you feeling now? ☐ Full of Energy ☐ Great! ☐ Content ☐ Tired ☐ Depleted
☐ Bummed out ☐ Worried ☐ OK ☐ Achy ☐ Angry

Have you been treated for any health conditions? ( )Yes ( )No What?__________________________

Do you now or have you ever had any of the following issues: C for current; P for previous; B for both

___ Cancer ___ Anemia ___ Cholesterol ___ Prostate / ovaries ___ Heart or Blood Pressure
___ Sinus ___ STD ___ Positive covid test ___ Allergy shots ___ Nervousness / Anxiety
___ Asthma ___ Dizziness ___ Breathing Problems ___ Bleeding Disorders ___ Digestive Disorders, Gas or Belching
___ Epilepsy ___ Cataracts ___ Hemorrhoids ___ Herniated Disc ___ Weight Management
___ Hernia ___ Cold sores ___ Thyroid Problems ___ Numbness / tingling ___ Depression

Primary care Doctor info: ____

List medications / supplements you are taking and why:____

____

____

____

____

Any x-rays taken (include CAT scans, MRI) and why : ____

Blood type: A+ A- O+ O- B+ B- AB+. AB- ☐ I don't know

Daily Liquid Habits: _____________ Oz of water consumed every day on average
__________ Alcohol/Day __________ Coffee/Caffeinated Tea-Cups/Day __________ Colas/ day

Approximate number of times you urinate during the day: ________ ☐ up at night to pee? _________times

Eating habits: ☐ Paleo ☐ Keto ☐ Vegetarian. ☐ Vegan ☐ Gluten-free ☐ Dieting? _______________
☐ Red meat-______Times per week, ☐ Fast food- _________ per week
Bowel movement : ________ daily. ☐ Always Regular ☐ Constipation ☐ Loose stool. ☐ Alternating

Exercise habits: () None () Light. () Moderate () Daily. Preferred Activity: ________________________
Daily steps distance or length of daily walk ______________________
Do you wear heel or foot supports? ( ) Yes ( ) No

Average number of hours per night sleep: ___________. Quality ___________ Why?
How old is your mattress? _______________

Do you have sufficient energy for your normal activities? ( )Yes ( )No If not, explain:

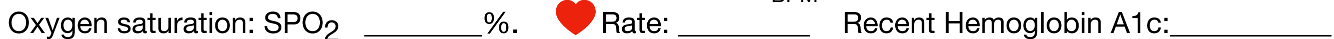
____

Are or have you ever been a smoker? ☐ No way, never ☐ Yes ☐ Current user _____. _Packs per day for _______Years
☐ Previously - last use was: ______________
Have you ☐ smoked, ☐ occasional MJ
☐ vaped / e-cig in the previous 14 days? Are you interested in quitting? ☐ Yes. ☐ Not now

Has your vision changed lately? ( )Yes ( )No
Glasses or contact lenses? ( )Yes ( )No 20/_______ vision Or diopter. OD. ___________. OS___________
[0 to -3.00 diopters is mild. -3.00 to -6.00 diopters is moderate. -6.00 to -9.00 diopters is severe.]
[OD stands for oculus dexter, the Latin phrase for "right eye." OS oculus sinister, for "left eye."]

Family History: give age and health problems. If deceased, give age at death and cause of death.
Father___________________________ Dad's Father _________________ Dad's Mother _________________
Mother __________________________Mom's Father___________________ Mom's Mother _________________
Brother/Sister. ____
Children: ____

Recent blood pressure: ☐ Near 120/80 (+/- 5) ☐ High ______ /______ ☐ Low ______ /________



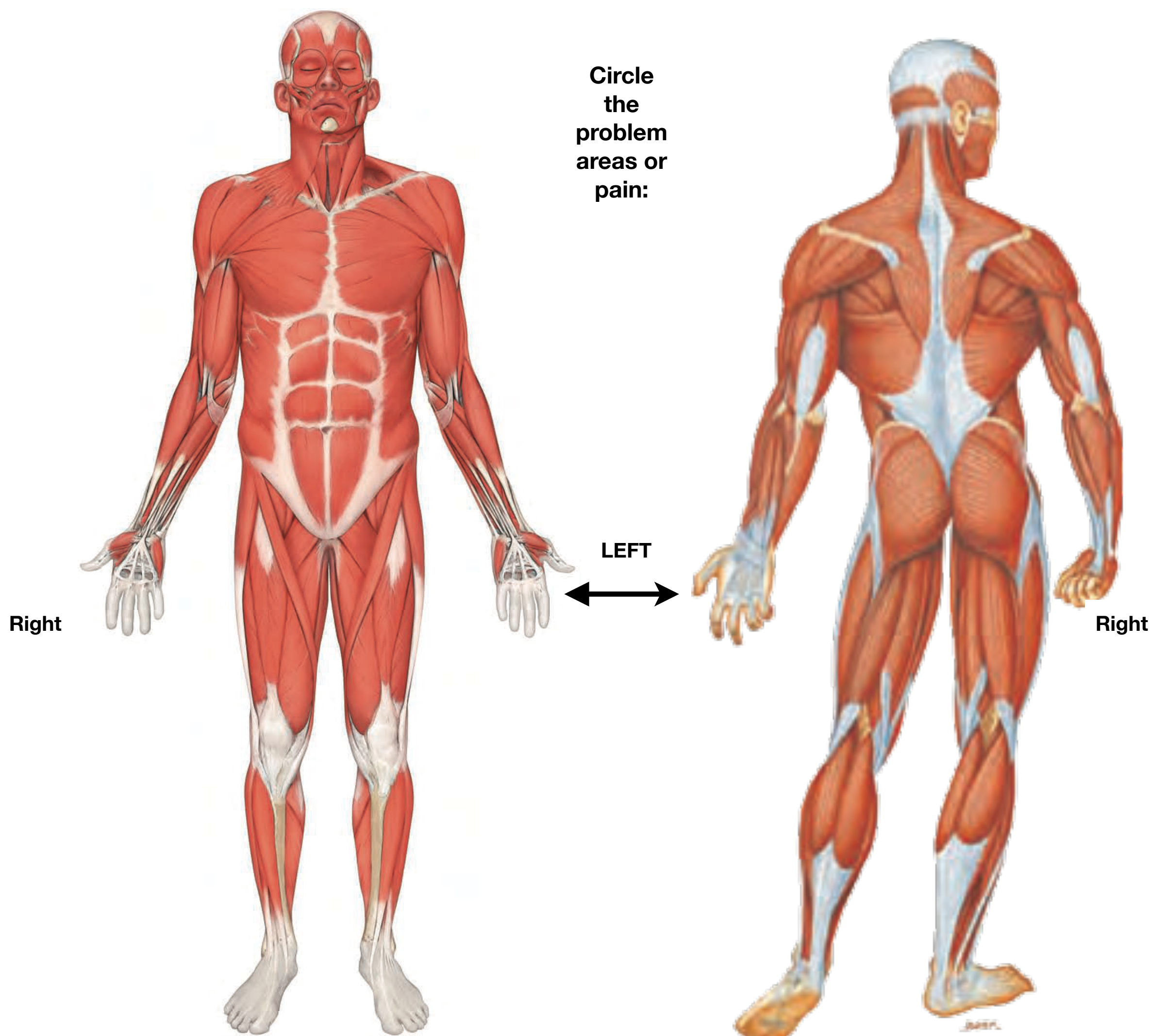
Oxygen saturation: SPO_2 ________%. Heart Rate: _________ BPM Recent Hemoglobin A1c:__________

Worst pain you ever experienced 10/10? ☐ Child birth ☐ Kidney stone ☐ Eye trauma ☐ Broken bone
Where and when:
Other: ____

____

Current areas of pain?
Please RATE on 1-10 scale

☐ Low back pain. ________/ 10. ☐ Left or ☐ Right
☐ Middle back pain ________/ 10. ☐ Left or ☐ Right
☐ Upper back / shoulder area pain ________/ 10 ________/ 10 L ☐. R ☐
☐ Neck / head pain ________/ 10 ________/ 10
☐ Hip / leg / knee /ankle / foot pain ________/ 10 ________/ 10 L ☐. R ☐
☐ organ / gut pain. ________/ 10



Extra Notes:

☐ I acknowledge having read, understood and signed the chiropractic consent form.
All Information provided above is accurate to the best of my recollection and knowledge:
I am personally responsible for the total amounts due to Hill Country Holistic Health (HCHH) for services rendered at the time of service. I understand HCHH does NOT accept workers compensation nor does HCHH file Medicare or Medicaid claims as our health services are non-covered. Any health and accident insurance policies are an arrangement between the insurance carrier and the insured party and any filing will be the responsibility of the insured party. HCHH will NOT be held responsible for any pre-existing medically diagnosed conditions nor for any diagnosis.

Signature ____