323 State Highway 31 E Chandler, TX 75758
Ph. (903) 849-2200   FX: (903) 849-2600

Hopson Chiropractic

Name ______________________________ Today's Date____________ Birth date ____________ Age________

Address ______________________________ City ____________________ State ______ Zip ___________

Preferred Name________________ Social Security # ________________ Driver's License # ________________

Home Phone____________________ Cell Phone________________________ Work Phone______________________

Referred By____ Gender ❑ M ❑ F

Significant Other's Name ________________________ Kid's Names and Ages ________________________

Your Employer ________________________ Type of Work ________________________

e-Mail Address ______________________________ Have you been to a chiropractor before? ▫ No ▫ Yes

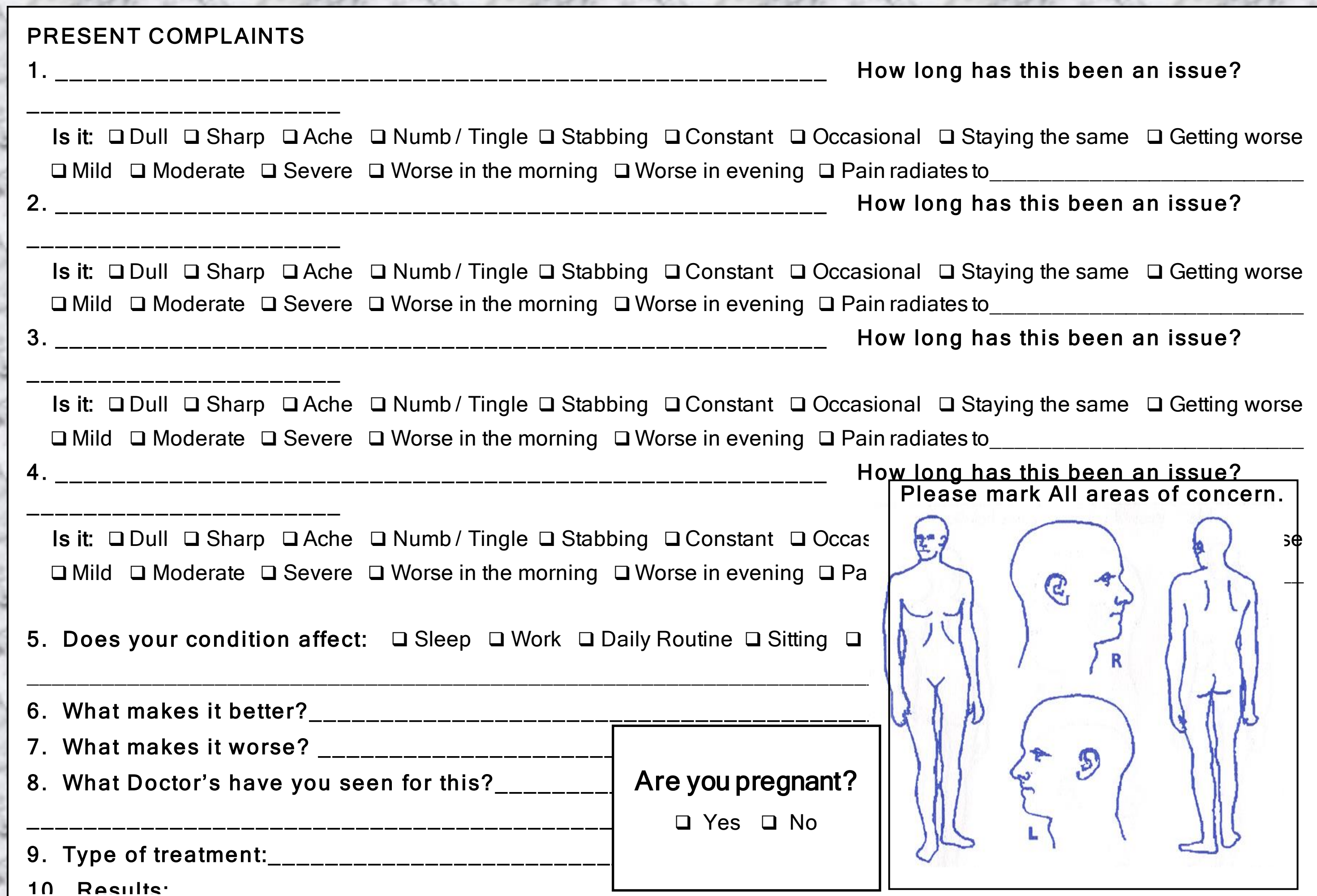
Emergency Contact ______________________________ ph # ______________________________

- 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 ❑ Occas
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pa

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑
____

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:

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.

323 State Highway 31 E Chandler, TX 75758

Hopson Chiropractic

Ph: (903) 849-2200 FX: (903) 849-2600

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

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other ______________________________			

1. List any medications are you taking:____
____
2. Please list all doctors you are currently seeing: _________________________________
____
3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name________________
____
____

PAST HISTORY

4. List any past auto collisions:______________________________ Was any care received?____________
5. List any past work injuries: ______________________________ Was any care received?____________
6. List any past sport, recreational, or home injuries____
7. Please describe any past conditions and treatment received: ______________________________
____
8. 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?_____________________________________