

Welcome To Hanley Chiropractic

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age ____ Today's Date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home # () _____ Work # () _____ Ext. _____ Soc. Sec. # _____ - _____ - _____
 _____ Male _____ Female Cell # () _____ E-mail Address _____

Your occupation _____ Work duties _____ **WOMEN ONLY: Are you pregnant? No _____ Yes _____**
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
 Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

Your Childs' Health Profile

Check any of the following conditions your child has suffered from in their lifetime:

- | | | | | | | | |
|--------------|--|----------------|--|--------------------|--|----------------------------------|--|
| Birth | | ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Digestive | | Recurring Colds | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breech | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recurring Flues | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C-section | <input type="checkbox"/> Yes <input type="checkbox"/> No | Appendicitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recurring Strep/ Sore Throats | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Forceps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Growing Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Natural | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bed Wetting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Suction Cup | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Juvenile Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temper Tantrums | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other _____ | | Car Accident | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaccinations | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Has your child ever been to a chiropractor? _____ If yes, when? _____ Reason? _____

Which contact sports does your child participate in? (circle) Soccer / Football / Gymnastics / Karate / Hockey / Basketball / Dance / Other _____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? Yes No (If yes, explain below under injuries/surgeries)

| Injuries/Surgeries your child has had : | Description | Date |
|---|-------------|-------|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No

Was this due to an accident/Trauma? Yes No

If Yes, explain.(ex. fall, auto, sports,) _____

Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels? _____

Severity: Mild Moderate Severe

Does this pain travel or radiate? If so, Where? _____

Quality: (mark all that apply)

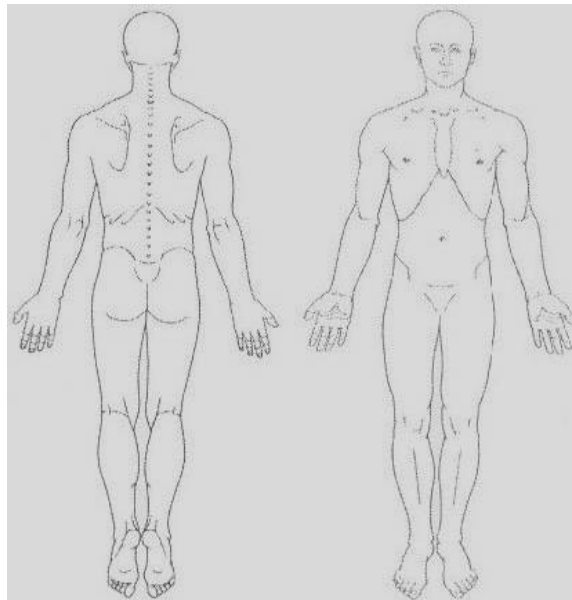
Burning Diffuse Dull/Aching Localized

Sharp Shooting Stabbing Tingling

Radiating Other _____

Is there anything that makes this better or worse? _____

Please mark on the diagram below the area of discomfort.



Timing:

- Worse AM Worse PM Worse W/ Activity Worse Sleeping
- Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

Rate the severity of your symptoms or condition on a scale from 1(least) to 10 (Severe). _____

Is the condition getting better, worse, or staying the same? _____

How often do you find yourself suffering from this problem? _____

How long does the problem last? (all the details of timing) _____

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

| | | | | |
|-----------------------|------------------------------------|--|---|--|
| Carrying Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Changing Positions | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sit to Stand | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing Stairs | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pet Care | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Extended Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Household Chores | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting Children | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Reading/Concentration | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Bathing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Dressing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Self Care – Shaving | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sexual Activities | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting Still | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Standing Still | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard Work | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Please List any effects that this may have on any Recreational Activities: _____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions? _____

Is there anything else you think the doctor should know concerning your condition? Yes _____ No _____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

____ Temporary Relief (Help the symptoms but do not fix the cause of the problem.)

____ Maximum Correction (Correct the problem for maximum healing & stability.)

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

On a scale of 1-10, ten being the highest, rate how important it is for you and your family to be at their highest health potential? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I have also, read and understand the Federal HIPPA ACT.

I therefore give my consent for my child to begin chiropractic examination and any other further care on this basis.

(Signature of Parent or Legal Guardian for child)

(Date)

Hanley Chiropractic
305 Vertin Boulevard
Shorewood, IL, 60404