TRIPLE H
CHIROPRACTIC

Heller Chiropractic, Health and Healing For All

Dr. Ginny Heller

1511 N. Durham, Houston, Texas 77008

832-658-9637

PATIENT INFORMATION:

Name: ____**Suffix**:____________________

Address:____

City:________________________**State**:_______________________**Zip**: ______________

Primary Phone:______________________________ **Mobile Phone**:__________________

Email: _____________________________________

Preferred Method of Contact (please circle): Primary Phone Mobile Phone Email

Date of Birth: ________________________ **Gender (circle)**: Male Female

Marital Status (Circle) : Single Married Other

Employment (Circle): Employed Student Self-Employed Retired Other

Employer: __________________________________

Emergency Contact Name: _____________________________**Relationship**: ___________

Emergency Contact Number: ___________________________

How did you hear about us: ____________________________

Personal/Family Medical History (please check all that apply, specify C = current, F= family, P=previously had)

- ☐ Cancer
- ☐ Bone Fracture
- ☐ Allergies
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Degenerative Disc Disease
- ☐ Headaches
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Concussion
- ☐ Asthma
- ☐ Pacemaker
- ☐ Multiple Sclerosis
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Pins, Screws, Plates
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Dislocated Joints
- ☐ Heart Disease / Problems
- ☐ Epilepsy
- ☐ Other:____________________________

Please list surgeries: ____

Please list current medications:

____

____

Do you use tobacco products of any kind (please circle)? YES NO IN THE PAST

If you answered yes to the previous question please indicate what type and the duration:

____

Patient History

Please describe what brings you in today:

____

____

Date of Onset: _________________________ **Is it getting (please circle)**: Better / Worse/ Same

Method of Injury / Cause of Complaint:

____

____

____

Have you seen anyone for treatment of this condition? **YES** or **NO**

If so, please tell us when and with whom and did it help you? ______________________________________

Does anything help the pain? **YES** or **NO**______________________________

Does anything aggravate the pain? **YES** or **NO**____

What is the quality of the pain? ____

How often is the pain present?____

Does the pain radiate to other areas? If yes please indicate where? **YES** or **NO** ____________________

Do you have any numbness or tingling in your body? **YES** or **NO**______________________________

Does the pain interfere at work, home or leisurely activities? If so, please indicate where and what. **YES** or **NO**

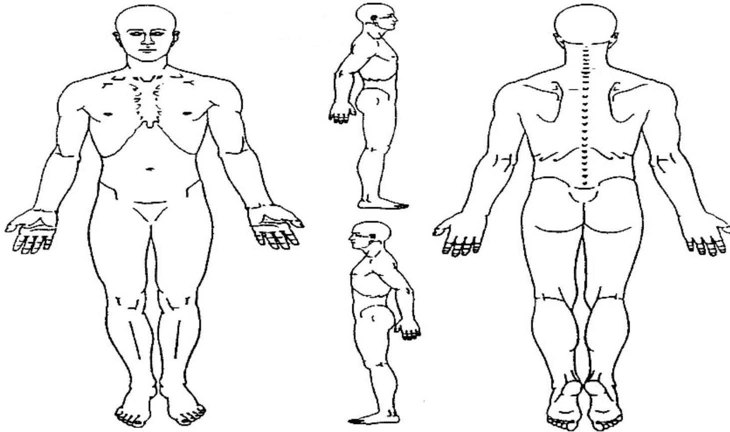
____

Have you had any imaging done on the area of chief complain? **YES** or **NO**

If so, please indicate MRI, CT Scan or X-ray, and what were the results**:** ____

Please indicate on the body below the areas in which you are experiencing pain. Please use the abbreviations below which reflect the type of discomfort that you are having.

P= Sharp Pain T=Tingling N= Numbness D=Dull Ache S=Stiff



Please circle your current pain level:

No Pain =0 1 2 3 4 5 6 7 8 9 10 = Worst

Patient Signature: ____________________________

Date: ____________________________