HOMZA CHIROPRACTIC WELLNESS & REHAB

5721 LINGLESTOWN RD. • HBG., PA 17112 • MAIN: (717) 541-9311 • HOME: (717) 469-1455 • FAX: (717) 540-1211

DR. JOHN J. HOMZA

DR. JOSEE L. HOMZA

Name:______________________________ Date:____________________

Address:____________________________ City/State/Zip: ______________

Email:______________________________ Date of Birth:_______________

Home/Cell/Work #:____

Marital Status:_______________________ Occupation:________________

Names of Spouse:__________________ Do you have children?____________

If yes, list their names and ages:

____

____

____

Who can we thank for referring you or how did you hear about our office?

____

Reason(s) for seeking services at Homza Chiropractic?

____

Is this preventing you from doing activities you otherwise enjoy doing?

____

Is there anything in your Neuro-Spinal System we should know about?
(surgeries, injuries, previous diagnosis)

____

Are you aware of your posture? Y N

Are you aware that Chiropractors work with the Nervous System? Y N

Are you aware that the Nervous System controls all other systems? Y N

Are you aware that misalignments can occur starting at birth? Y N

History of Traumas (accidents, falls, sports injuries, hospitalizations?):

____

History of Chemical Stress past or current (drugs/alcohol, allergies/environmental toxins, smoking, artificial sweeteners?):

____

History of Emotional Stress past or current (anxiety, depression, loss of loved one, fertility issues, family life, etc.):

____

Please list any medications/supplements you are currently taking or have take in past 2 months:

____

How many hours of sleep do you get per day?______________Quality?________

How many hours of exercise do you get per week?________________________

Do you sit at your home/job for more than 4 hours a day?__________________

What is the major stress affecting your health today?

____

What do you enjoy doing to "de-stress" your life?

____

Have you seen a chiropractor in the past? Y N
If yes, how long ago?___________________________

With each complaint please fill out the following:

The primary and secondary health problem I would like to get rid of would be:

A.____________________________ B.__________________________________

When did it begin? (last week, last month, 1 year ago, other)

A.____________________________ B.__________________________________

How did it begin? (i.e. accident, fall, woke up with it, other?)

A.____________________________ B.__________________________________

What makes this problem worse? (sitting, standing, other)

A.____________________________ B.__________________________________

How often is this occurring? (constantly, morning, evening, daily, 2x/week, weekly, monthly, intermittent, 2x/year, other)

A.____________________________ B.__________________________________

What makes this problem better?

A.____________________________ B.__________________________________

Describe the quality of the symptom (sharp, burning, stabbing, electric, numbness, tingling, pressure, achy, other)

A.____________________________ B.__________________________________

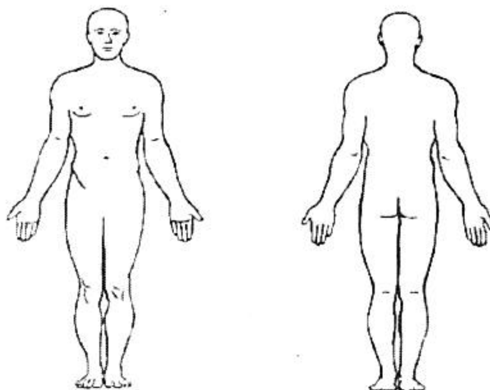
Does this problem occur with other problems (i.e. hand or leg numbness, stomach problems, sinusitis, irritable bowel, other)

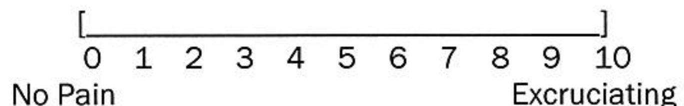
A.____________________________ B.__________________________________

Does the condition interfere with:

__work __walking
__sleep __personal care
__lifting objects __social life
__concentration __sitting
__driving in a car __standing

Mark an **X** on the picture where you have pain or other symptoms





[_________________________________]
0 1 2 3 4 5 6 7 8 9 10
No Pain Excruciating

Name of Medical Doctor______________________

Are you currently being treated for this conditon by your MD? Circle: YES or NO

Your Health Concerns & Secondary Conditions

Please circle secondary conditions of concern to you:

Headaches
Migraines
Dizziness
Allergies
Fatigue

Sore Throat
Asthma
Heart Conditions

Mid-Back Pain
Bronchitis
Indigestion
Ulcers
Stomach Issues

Low Back Pain
IBS
Gas Pain
Buttocks Pain
Hip Pain
Fertility Issues

Sinus Infection
Ear Trouble (ringing, infections)
Head Colds
Hearing Difficulties
Difficulty Concentrating

Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness

Difficulty Breathing
Pneumonia
Gallbladder Conditions
Kidney Problems
Diabetes

Constipation
Colitis
Leg/Foot Numbness
Bladder Problems
Menstrual Problems
Arthritis