Baker
CHIROPRACTIC | WELLNESS

HIATAL HERNIA

Your Name: _____

Have you been diagnosed with a hiatal hernia by a medical doctor (MD)?
_____YES
_____NO

If yes, when (date)? _____

Are you taking medications currently for your hiatal hernia?
_____YES
_____NO

If yes, list medication and dosage:

_____

Please list any side effects you are experiencing from the medication?

_____

What symptoms you are experiencing?
Please mark **P** for in the Past, **C** for Currently Have and **N** for Never

_____ Pain _____Acid Reflux _____Indigestion

_____Difficulty Breathing _____Symptoms resembling a heart attack

_____Lump in chest or throat

On a scale of 1 to 10 (10 being the most severe), how would you rate your pain? _____

How are your symptoms affecting your life?

_____

On a scale of 1 to 10 (10 being extremely committed), how committed are you to fixing your problem?

_____

List the Top 3 most physically challenging symptoms:

1. _____
2. _____
3. _____

List the Top 3 most emotionally challenging symptoms:

1. _____
2. _____
3. _____

Do you feel short tempered while suffering from a hiatal hernia?

_____YES

_____NO

How has your hiatal hernia affected your loved ones?

_____

Did you try any home remedies? If yes, what and how did you hear about the home remedy?

_____

How did you find our practice?

_____

Did you consider seeking help at another doctor's office?

_____YES

_____NO

If yes, why did you select Baker Chiropractic and Wellness?

_____

If online, did you search with your phone or computer?

_____ Phone

_____Computer

What is the most important thing to you about getting this condition resolved?

_____