Confidential Patient Health Record

***Today's Date*:____/____/_____**

How did you hear about us? □ **Family** _____ □ **Friend** _____ □ **Co-Worker** _____
□ **Close to home/work** □ **Dr.** _____ □ **Yellow pages** □ **Drove by** □ **Hospital** □ **Insurance Plan**

Personal Information

Title: □ **Mr.** □ **Ms.** □ **Mrs.** □ **Dr.** □ **Rev.** □ **Miss** □ **Prof.** □ **other:** _____

Last:_____ **First:**_____ **Middle:** _____

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **Social Security #:** _____-_____-_____

Marital Status: □ **Single** □ **Married** □ **Widowed** □ **Divorced** □ **Separated**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Cell Phone: (_____) _____-_____ **ext** _____ **Fax #:** (_____) _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Emergency Contact

Last:_____ **First:**_____ **Middle:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Relationship: □ **Spouse** □ **Relative** □ **Friend** □ **Other** _____

Home Phone: (_____) _____-_____ **ext** _____ **Cell/Work Phone:** (_____) _____-_____ **ext** _____

Employment Information

Business Name: _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____-_____ **Fax #:** (_____) _____-_____

Occupation/Job Title: _____ **Job Description** _____

Insurance Information:

Primary Care Physician: _____

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ **Patient Signature:** _____

Guardian /Spouse's Signature of Authorizing Care: _____ **Date:** _____

Current Health Condition

WHY ARE YOU HERE TODAY?:

_____

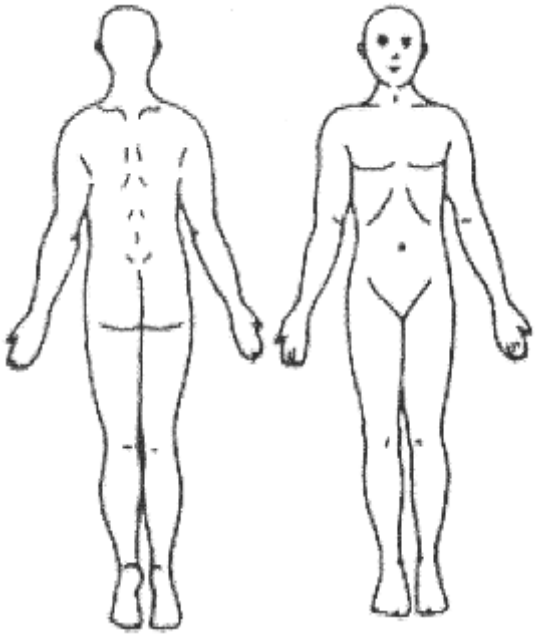
When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? □ **Yes** □ **No.** **When?** _____

Do you SUFFER with ANY OTHER Conditions that need attention?

_____

_____



CIRCLE YOUR LEVEL OF PAIN:

At Rest:

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

With Activity:

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

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ **chills**	☐ **fatigue**	☐ **night sweats**	☐ **weight loss**
☐ **daytime drowsiness**	☐ **fever**	☐ **weight gain**	

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **blindness**	☐ **change in vision**	☐ **field cuts**	☐ **photophobia**
☐ **blurred vision**	☐ **double vision**	☐ **glaucoma**	☐ **tearing**
☐ **cataracts**	☐ **eye pain**	☐ **itching**	☐ **wear glasses/contacts**

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **bleeding**	☐ **fainting**	☐ **hoarseness**	☐ **rhinorrhea (runny nose)**	☐ **tinnitus (ringing in ears)**
☐ **difficulty swallowing**	☐ **frequent sore throats**	☐ **loss of sense of smell**	☐ **sinus infections**	☐ **TMJ problems**
☐ **dizziness**	☐ **headaches**	☐ **nasal congestion**	☐ **snoring**	
☐ **ear drainage**	☐ **hearing loss**	☐ **nosebleeds**	☐ **sore throat**	
☐ **ear pain**	☐ **history of head injury**	☐ **postnasal drip**		

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **asthma**	☐ **coughing up blood**	☐ **sputum production**
☐ **cough**	☐ **shortness of breath**	☐ **wheezing**

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **angina (chest pain or discomfort)**	☐ **high blood pressure**	☐ **shortness of breath with exertion or exercise**
☐ **chest pain**	☐ **low blood pressure**	☐ **swelling of legs**
☐ **claudication (leg pain/ache)**	☐ **orthopnea (difficulty breathing lying down)**	☐ **ulcers**
☐ **heart murmur**	☐ **palpitations**	☐ **varicose veins**
☐ **heart problems**	☐ **paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)**	

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain	☐ diarrhea	☐ indigestion	☐ abnormal stool color	☐ vomiting blood
☐ belching	☐ difficulty swallowing	☐ jaundice	☐ abnormal stool consistency	☐ vomiting
☐ constipation	☐ heartburn	☐ nausea	☐ hemorrhoids	☐ rectal bleeding

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ burning urination	☐ frequent urination	☐ irregular menstruation	☐ pregnancy
☐ cramps	☐ hormone therapy	☐ menopausal changes	☐ urine retention

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination	☐ frequent urination	☐ prostate problems
☐ erectile dysfunction	☐ hesitancy/ dribbling	☐ urine retention

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ cold intolerance	☐ excessive hunger	☐ goiter	☐ unusual hair growth
☐ diabetes	☐ excessive thirst	☐ hair loss	☐ voice changes
☐ excessive appetite	☐ abnormal frequency of urination	☐ heat intolerance	

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture	☐ hair loss	☐ itching	☐ skin lesions / ulcers
☐ changes in skin color	☐ hives	☐ paresthesias	☐ varicose veins
☐ hair growth	☐ history of skin disorders	☐ rash	

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness	☐ limb weakness	☐ numbness	☐ slurred speech	☐ tremor
☐ facial weakness	☐ loss of consciousness	☐ seizures	☐ stress	☐ unsteadiness of gait/ loss of balance
☐ headache	☐ loss of memory	☐ sleep disturbance	☐ strokes	

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anxiety	☐ bi-polar disorder	☐ depression	☐ mood change
☐ loss or change in appetite	☐ confusion	☐ insomnia	
☐ behavioral change	☐ convulsions	☐ memory loss	

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphalaxis	☐ itching	☐ chronic nasal congestion	☐ sneezing
☐ food intolerance	☐ acute nasal congestion	☐ rash	

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia	☐ blood clotting	☐ bruising easily	☐ lymph node swelling
☐ bleeding	☐ blood transfusion	☐ fatigue	

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
☐ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Name of Doctor seen for THIS CONDITION? (Name) _____
Type of Treatment: _____ Were you satisfied with the results of your treatment? ☐ Yes ☐ No

Explain: _____

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Chiropractors's Name: _____ Location: _____
Date of Last Visit: _____
Were you satisfied with your care? ☐ Yes ☐ No. If No, Why? _____
Do you wear any of the following? ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics ☐ Other_____
For how long? _____ Were they prescribed by a doctor? ☐ Yes or ☐ No.

Current Medications, Vitamins, Supplements: **List ANY/ALL that you are CURRENTLY taking.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- ☐ ADD
- ☐ atopic dermatitis (eczema)
- ☐ allergies/hayfever
- ☐ anemia
- ☐ asthma
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ depression
- ☐ diabetes
- ☐ ear infections
- ☐ fetal drug exposure
- ☐ food allergies (list below)
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps
- ☐ psoriasis
- ☐ rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other:

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? ☐ yes or ☐ no.

Adult Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- ☐ ADD
- ☐ alzheimers
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes (insulin dep)
- ☐ diabetes (non insulin)
- ☐ eczema
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenzal pneumonia
- ☐ liver disease
- ☐ lung disease
- ☐ lupus erythema (discoid)
- ☐ lupus erythema (systemic)
- ☐ multiple sclerosis
- ☐ parkinson's disease
- ☐ unspecified pleural effusion
- ☐ pneumonia
- ☐ psoriasis
- ☐ psychiatric problems
- ☐ scoliosis
- ☐ seizures
- ☐ shingles
- ☐ past history of similar symptoms
- ☐ STD's (unspecified)
- ☐ suicide attempt(s)
- ☐ thyroid problems
- ☐ vertigo
- ☐ other:

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

_____

_____

Females ONLY: Ob/Gyn **Mark all that apply below.**

If you have been pregnant in the past, please fill in the appropriate information below.

_____Number of complicated pregnancies **_____ Number of uncomplicated pregnancies**

_____Number of C-sections **_____Number of vaginal deliveries**

_____Number of miscarriages

I… **☐ am currently pregnant** **☐ am NOT currently pregnant**

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- ☐ back injury
- ☐ broken bones
- ☐ disability (ies)
- ☐ fall (severe)
- ☐ fracture
- ☐ head injury (loss of consciousness)
- ☐ head injury (no loss of consciousness)
- ☐ industrial accident
- ☐ joint injury
- ☐ laceration (severe)
- ☐ motor vehicle accident
- ☐ soft tissue injury (mild)
- ☐ soft tissue injury (moderate)
- ☐ soft tissue injury (severe)
- ☐ other:

Family History:	**Mark all that apply below. List any specific conditions past or present after has/had:**			
father	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
mother	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
paternal grandfather	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
paternal grandmother	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
maternal grandfather	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
maternal grandmother	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
son (s)	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
daughter(s)	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
brother(s)	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**
sister(s)	**□ alive**	**□ deceased**	**□ no significant disease**	**□ has/had:**

Social History: **Mark all that apply below.**

Alcohol: □ do not drink alcohol □ social consumption only □ drink regularly

My Dietary Intake consists mainly of the following: (mark all that apply)

□ high fat	**□ high salt**	**□ low fiber**
□ high fiber	**□ low calorie**	**□ low salt**
□ high protein	**□ low carbohydrate**	**□ low sugar**

Substance: □ never used illegal/IV drugs □ has not used illegal drugs since _____ .
□ used illegal drugs for _____ (how long?)

My Amount of Exercise: (mark all that apply)

□ None	**□ Occasional**	**□ Regularly**

If Exercising please state what kind: _____