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.**

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

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **SSN:** _____

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

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

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

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

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

Children (Names and Ages): _____

Emergency Contact

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

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

Home Phone: (_____**)** _____-_____ **ext** _____ **Cell Phone: (**_____**)** _____-_____ **ext** ___

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

Employment Information

Business Name: _____

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

Employer's Email Address: _____

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

Current Health Condition

Unwanted Condition (Why you are here today?):_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

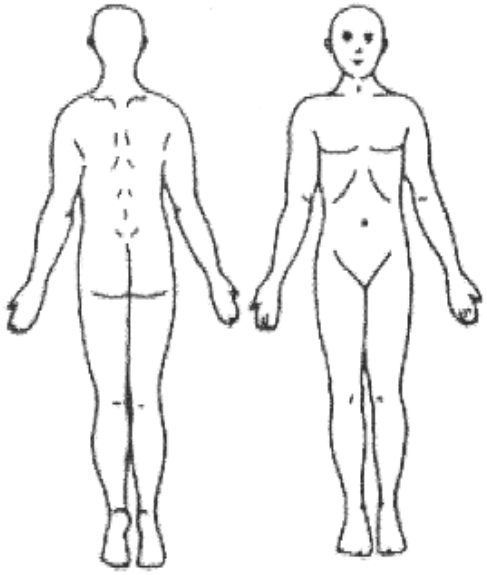
_____

Patient Name: _____ Date:_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

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



When did this Condition BEGIN? _____/_____/_____

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

Is the Condition: □ Auto Related □ Job Related □ Home Injury

□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

Explain: _____

_____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

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

Respiration:	**□ I DENY having any of the symptoms or problems listed below.**	
□ asthma	**□ coughing up blood**	**□ sputum production**
□ cough	**□ shortness of breath**	**□ wheezing**

Patient Name: _____ Date:_____

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 caliber**	☐ **vomiting blood**
☐ **belching**	☐ **difficulty swallowing**	☐ **jaundice**	☐ **abnormal stool color**	
☐ **black - tarry stools**	☐ **heartburn**	☐ **nausea**	☐ **abnormal stool consistency**	
☐ **constipation**	☐ **hemorrhoids**	☐ **rectal bleeding**	☐ **vomiting**	

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

☐ **birth control**	☐ **cramps**	☐ **irregular menstruation**	☐ **vaginal bleeding**
☐ **breast lumps/pain**	☐ **frequent urination**	☐ **pregnancy**	☐ **vaginal discharge**
☐ **burning urination**	☐ **hormone therapy**	☐ **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**	☐ **varicosities**
☐ **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.**

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

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**	

Patient Name: _____ Date:_____

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

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

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____
Type of Treatment: _____ Was the treatment beneficial in resolving condition? □ Yes □ No

Explain: _____

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

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

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

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

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

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

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

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? □ yes or □ no.

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

□ angioplasty	□ cosmetic	□ hysterectomy	□ pacemaker insertion
□ appendectomy	□ D & C	□ joint reconstruction	□ rotator cuff
□ caesarian section	□ dental surgery	□ joint replacement	□ spinal fusion
□ cardiac catheterization	□ gall bladder	□ knee repair	□ tonsilectomy
□ carpal tunnel repair	□ hemorrhoidectomy	□ laminectomy	□ other:
□ coronary artery bypass	□ hernia repair	□ mastectomy	

Patient Name: _____ Date:_____

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

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

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month
Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt
☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar
Education (please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High ☐ Votech
☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐ Post High School Classes ☐ Assoc/Technical Degree
☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate ☐ Other: _____
Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____
Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking
☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific):_____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____-_____-_____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐ No Date:____/____/_____Time: _____am/pm

Carrier: _____ Policy # _____

Carriers Phone #: (_____) _____-_____ Adjuster: _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____