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: ____________________________

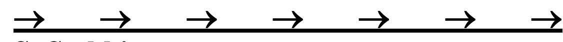
Occupation/Job Title: __________________________ **Job Description** ______________________________________

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.

____

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

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

t pain or discomfort) ☐ high blood pressure ☐ shortness of breath with exertion or exercise
☐ low blood pressure ☐ swelling of legs
(leg pain/ache) ☐ orthopnea (difficulty breathing lying down) ☐ ulcers
ur ☐ palpitations ☐ varicose veins
ems ☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

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

minal 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.**

ı 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.**

ing 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

Patient Name: ______________________ Date: ______________

☐ 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
- ☐ 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:

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:

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

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 #: ____

Patient Name: ____ Date:________________

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: ______________