

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
Marital Status: Single Married Widowed Divorced Separated
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Home Phone: (____) _____ - _____ ext _____ Work Phone: (____) _____ - _____ ext _____
Cell Phone: (____) _____ - _____ ext _____ SS# _____
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? _____

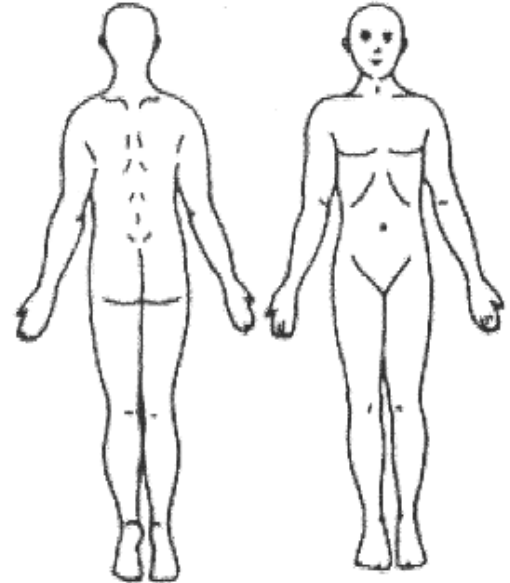
Is the Condition: Auto Related Job Related Home Injury
Slip or Fall Lifting Slept Wrong Unknown Cause Other

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
difficulty fainting hoarseness rhinorrhea TMJ problems
swallowing (runny nose)
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	

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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

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 (discoïd) | 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.

Patient Name: _____

Date: _____

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	

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: _____

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: _____