

Confidential Patient Health Record

Today's Date: ____ / ____ / ____

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

Birth Date: ____ / ____ / ____ **Age:** ____ **Sex:** M / F / T

Marital Status: Single Married/Partner/DP/CU Divorced Widowed

Address: _____ **Apt #** _____

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

Referred by: _____

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

Cell Phone: (____) _____ - _____ **Website** _____

Email Address: _____ **Spouse/Partner):** _____

Children (Names and Ages): _____

Name & Address of Primary Care Physician _____

Are here today for treatment of an injury received at work or from a car accident? _____

Emergency Contact

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

Relationship: Spouse/Partner Relative Friend Other _____

Home Phone: (____) _____ - _____ **Cell Phone:** (____) _____ - _____

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

Employment Information

Business Name: _____

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

Work Email Address: _____ **Website** _____

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

Current Health Condition

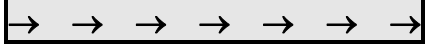
What has brought you to our office?

Patient Name: _____

Date: _____

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

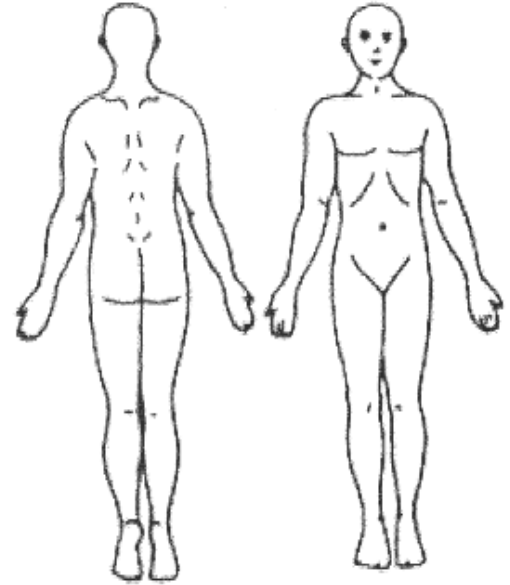
Slip or Fall Lifting Slept Wrong Unknown Cause Other

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: Check the box if you have/had these symptoms or problems listed below.

- chills
- fatigue
- night sweats
- weight loss
- daytime drowsiness
- fever
- weight gain

Eyes/Vision:

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

Ears, Nose and Throat:

- 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:

- asthma
- coughing up blood
- sputum production
- cough
- shortness of breath
- wheezing

Patient Name: _____

Date: _____

Cardiovascular:

- angina (chest pain or discomfort) high blood pressure shortness of breath
- 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:

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

Female:

- birth control cramps irregular menstruation vaginal bleeding
- breast lumps/pain frequent urination pregnancy vaginal discharge
- burning urination hormone therapy urine retention

Male:

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

Endocrine:

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

Skin:

- 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:

- 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:

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

Allergy:

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

Hematologic:

- 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 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.

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

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

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

Patient Name: _____

Date: _____

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.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | <input type="checkbox"/> other: |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

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

- | | | | | | |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Social History:

- Alcohol: None Quit Social consumption Beer Wine Liquor
- Tobacco: None Quit Lives with smoker
- Smoker How many? _____ How Long? _____
- Prescription drug _____ Other _____
- Diet: No specific diet High Fiber High Protein Low Calorie Low Carbohydrate
- Low Salt Low Sugar Vegan Vegetarian Other: _____
- Education: High School GED College Graduate School Other

Insurance Information:

- Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es)) Myself ONLY
- Spouse Worker's Comp Auto Insurance Medicare Other (be specific): _____
- Personal Health Insurance Carrier: _____ Health ID Card #: _____
- Policy Holder's Name: _____ Group #: _____
- Policy Holder's Date of Birth: _____ - _____ - _____ Primary Care Physician: _____

Patient Name: _____

Date: _____

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: _____