Confidential Patient Health Record

Today's Date: _____ / _____ / _____

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

Personal Information

Name: _____ Birth Date: _____ / _____ / _____ Age: _____

Address: _____ Sex: M or F SS#: _____

City: _____ State: _____ Zip: _____

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Email: _____

Home Ph#: (____)_____ Cell Ph#: (____)_____

Children (Names and Ages): _____

Primary Care Physician: _____ Physician's Ph#: (____)_____

Employment Information

Business Name: _____ Occupation/Job Title: _____

Work Ph#: (____)_____ ext _____ Work Email: _____

Work Fax: (____)_____ ext _____

Emergency Contact

Name: _____ Contact Ph#: (____)_____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other: _____ Contact Cell Ph# (____)_____

Current Health Condition

Unwanted Health Condition(s): _____

_____

When did this Condition(s) begin? (on or about) _____ / _____ / _____

Has this Condition(s) occurred before? ☐ YES ☐ NO

Other Doctors Seen for this Condition(s): ☐ YES ☐ NO

Who? _____

Type of Treatment: _____

Was the treatment beneficial in resolving condition? ☐ YES ☐ NO

Is Condition(s): ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Slip or Fall
☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

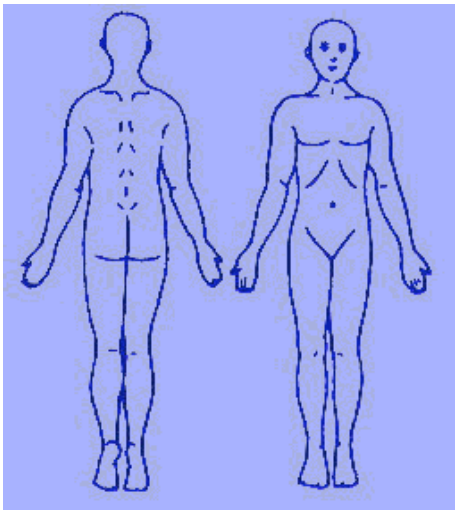
Explain: _____

Do you suffer from **any other** condition than which you are now consulting us?

Explain: _____

_____

Do you wear a shoe lift or orthotics? ☐ YES ☐ NO



PLEASE LABEL ON THE DIAGRAM THE AREA(S) OF DISCOMFORT:

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

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?

Childhood Illness(es): **CHECK any that apply. CIRCLE any CURRENT conditions.**

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

Additional Information: _____

Adult Illness(es): **CHECK any that apply. CIRCLE any CURRENT conditions.**

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

INTAKE

- ☐ **coffee**
- ☐ **tea**
- ☐ **alcohol**
- ☐ **sugar**
- ☐ **cigarettes**

DOCTOR: Are child/adult illnesses listed contributory to the CURRENT condition? ☐ YES or ☐ NO

Surgery(ies): **CHECK all surgical procedures. Write the DATE of the procedure immediately afterward.**

- ☐ **angioplasty**
- ☐ **appendectomy**
- ☐ **c-section**
- ☐ **knee repair**
- ☐ **carpal repair**
- ☐ **hernia repair**
- ☐ **cosmetic**
- ☐ **D & C**
- ☐ **dental surgery**
- ☐ **gall bladder**
- ☐ **rotator cuff**
- ☐ **mastectomy**
- ☐ **hysterectomy**
- ☐ **joint reconstruction**
- ☐ **joint replacement**
- ☐ **cardiac catheterization**
- ☐ **laminectomy**
- ☐ **other**: _____
- ☐ **pacemaker insertion**
- ☐ **hemorrhoidectomy**
- ☐ **spinal fusion**
- ☐ **tonsillectomy**
- ☐ **coronary bypass**

Additional Information: _____

_____

Injury (ies): **CHECK 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**: _____

Additional Information: _____

_____

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 or have had 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 or have had 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** ☐ **snoring** ☐ **dental implants** ☐ **fainting**
☐ **hoarseness** ☐ **rhinorrhea** (runny nose) ☐ **TMJ problems** ☐ **discharge** ☐ **ear infections** ☐ **loss of smell**
☐ **sinus infections** ☐ **difficulty swallowing** ☐ **headaches** ☐ **nasal congestion** ☐ **tinnitus** (ringing in ears) ☐ **dizziness**

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

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

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

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

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

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

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** ☐ **vaginal discharge** ☐ **burning urination** ☐ **hormone therapy** ☐ **urine retention**
Are you pregnant? ☐ Yes ☐ No Date of last period: ___ / ___ / ___

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

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

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

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

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

☐ **changes in nail texture** ☐ **hair loss** ☐ **itching** ☐ **skin lesions / ulcers** ☐ **changes in skin color** ☐ **hives**
☐ **rash** ☐ **varicosities** ☐ **hair growth** ☐ **history of skin disorders** ☐ **paresthesia** (numbness, prickling or tingling)

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

☐ **anaphalaxis** (history of) ☐ **itching** ☐ **nasal congestion** ☐ **sneezing** ☐ **food intolerance** ☐ **rash**

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

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

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

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

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

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

Family History:	**CHECK all that apply below. LIST any specific conditions, past or present, after "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**: _____

Additional Information: _____

_____

Type of care desired:

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ **Relief Care** ☐ **Corrective Care** ☐ **Check here if you want the Doctor to select the type of care appropriate for your condition**

_____ _____

Patient's Signature Date

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives 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's Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's
Signature of Authorizing Care: _____ Date: _____