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:**_____ **Gender: 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.

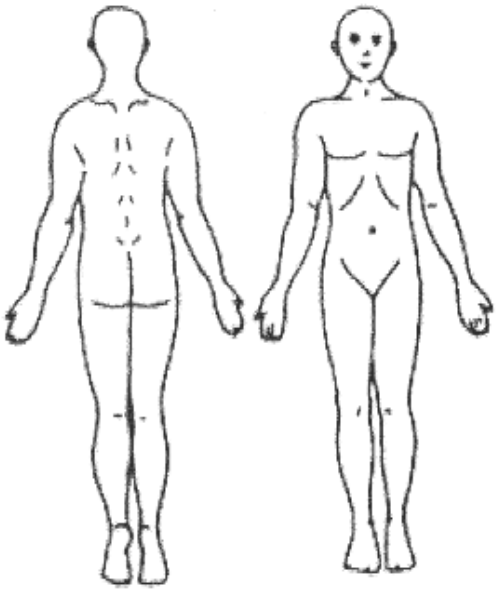
_____

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: **ONLY check the symptoms or problems you currently have.**

☐ **chills**	☐ **fatigue**	☐ **night sweats**	☐ **weight loss**
☐ **daytime drowsiness**	☐ **fever**	☐ **weight gain**	

Eyes/Vision: **ONLY check the symptoms or problems you currently have.**

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

Ears, Nose and Throat: **ONLY check the symptoms or problems you currently have.**

☐ **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: **ONLY check the symptoms or problems you currently have.**

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

Patient Name: _____ Date:_____

Cardiovascular: ONLY check the symptoms or problems you currently have.		
☐ 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: ONLY check the symptoms or problems you currently have.				
☐ 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: ONLY check the symptoms or problems you currently have.			
☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal bleeding
☐ breast lumps/pain	☐ frequent urination	☐ pregnancy	☐ vaginal discharge
☐ burning urination	☐ hormone therapy	☐ urine retention	

Male: ONLY check the symptoms or problems you currently have.		
☐ burning urination	☐ frequent urination	☐ prostate problems
☐ erectile dysfunction	☐ hesitancy/ dribbling	☐ urine retention

Endocrine: ONLY check the symptoms or problems you currently have.			
☐ cold intolerance	☐ excessive hunger	☐ goiter	☐ unusual hair growth
☐ diabetes	☐ excessive thirst	☐ hair loss	☐ voice changes
☐ excessive appetite	☐ abnormal frequency of urination	☐ heat intolerance	

Skin: ONLY check the symptoms or problems you currently have.			
☐ 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: ONLY check the symptoms or problems you currently have.				
☐ 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: ONLY check the symptoms or problems you currently have.			
☐ anhedonia	☐ behavioral change	☐ convulsions	☐ memory loss
☐ anxiety	☐ bi-polar disorder	☐ depression	☐ mood change
☐ loss or change in appetite	☐ confusion	☐ insomnia	

Allergy: ONLY check the symptoms or problems you currently have.			
☐ anaphalaxis	☐ itching	☐ chronic nasal congestion	☐ sneezing
☐ food intolerance	☐ acute nasal congestion	☐ rash	

Hematologic: ONLY check the symptoms or problems you currently have.			
☐ anemia	☐ blood clotting	☐ bruising easily	☐ lymph node swelling
☐ bleeding	☐ blood transfusion	☐ fatigue	

Drug Allergy: ☐ I DENY having any drug allergy.

☐ List any allergies: _____

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: _____

Primary Pharmacy: _____ Phone:_____

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
☐ Alzheimer's	☐ depression	☐ influenzas - 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	☐ tonsillectomy
☐ 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 / ☐ Daily ☐ Weekly ☐ Monthly

Diet: ☐ 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 ☐ Some College Classes ☐ 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 Any Tobacco Use ☐ Do Not Smoke Cigars, Cigarettes, or Pipe ☐ Live with a Smoker ☐ Quit Smoking
☐ Smoke Tobacco: _____ (#) Per Day ☐ Chew Tobacco: _____ (#) Per Day, - ☐ Daily ☐ Weekly ☐ Monthly

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:** _____

Modifying Factors: Patient Name: _____ Date: _____

Symptoms Better With: ☐ **nothing helps** ☐ **activity** ☐ **bending** ☐ **applying cold** ☐ **applying heat**
☐ **massage** ☐ **movement** ☐ **OTC meds** ☐ **Rx meds** ☐ **rest**
☐ **stretching** ☐ **sitting** ☐ **standing** ☐ **twisting** ☐ **walking**

Symptoms Worse With: **(as noted in Social History)**

Daily Activities: Effects of Current Condition on Performance

No Effect ◄——————————► Unable to Perform

	0/10	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10
Bending:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Care –Infirm Family:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Carrying Groceries:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Change Posn–Sit-Stand:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Climb Stairs:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Driving:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Extended Computer Use:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feeding:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Household Chores:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kneeling:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lift Children:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lifting:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pet Care:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reading (Concentration):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self Care:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self Care–Bathing:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self Care–Dressing:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Self Care–Shaving:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Activities:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Static Sitting:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Static Standing:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Yard Work:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Employment:

Occupation/Job Title: _____ **Work:** _____ **hrs / day or week**
Description of Work: _____

Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)
Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)
Lifting Postures: ☐ **with Arms** ☐ **High Near** ☐ **from Knee** ☐ **Off Posture** ☐ **from Torso**
Work Activity Postures: (hrs/day)
☐ **bending: _____h/d** ☐ **climbing: _____h/d** ☐ **kneeling: _____h/d** ☐ **pulling: _____h/d** ☐ **pushing: _____h/d**
☐ **reaching: _____h/d** ☐ **sitting: _____h/d** ☐ **standing: _____h/d** ☐ **twisting: _____h/d** ☐ **walking: _____h/d**
Repetitive Activities: (hrs/day)
☐ **assembly/fine manipulation: _____h/d** ☐ **computer use/typing: _____ h/d** ☐ **grasping: _____ h/d**
☐ **hand tool use: _____ h/d** ☐ **operation of machinery controls: _____ h/d** ☐ **phone use: _____h/d**

Condition's Effect On Job Performance:

☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited ability) ☐ **Mod/Sev** Limited Duty ☐ **Sev** No Limited Duty ☐ **Sev** (can't do limited duty)

Recreational Activity: Effects of Current Condition on Performance

_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (Limited) ☐ **Sev** Unable to Perform
_____ ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (Limited) ☐ **Sev** Unable to Perform