## Confidential Patient Health Record

***Today's Date:*___/____/_______**

***How did you hear about us?*** **Family _______________ Friend __________________ Co-Worker ________________**
**Close to home/work  Dr. _____________  Yellow pages / online  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*

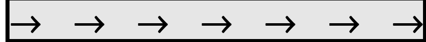
**Unwanted Condition** (Why you are here today?):_______________

________________________________________________________

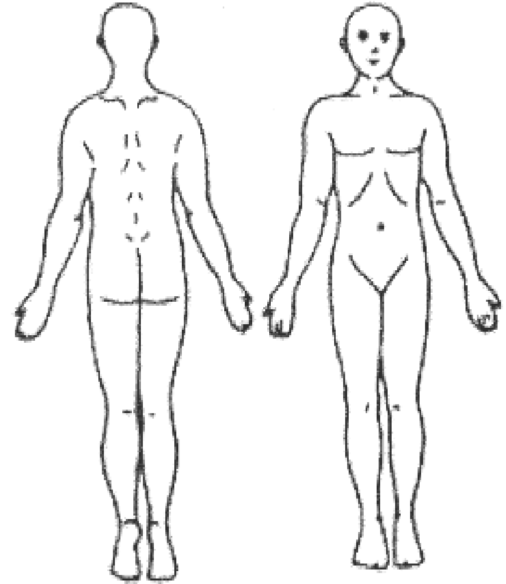
**Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.**

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 (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 |

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** | |

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.**

**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.**

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:** _____________