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 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

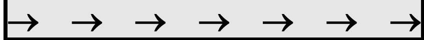
Unwanted Condition (Why you are here today?):____

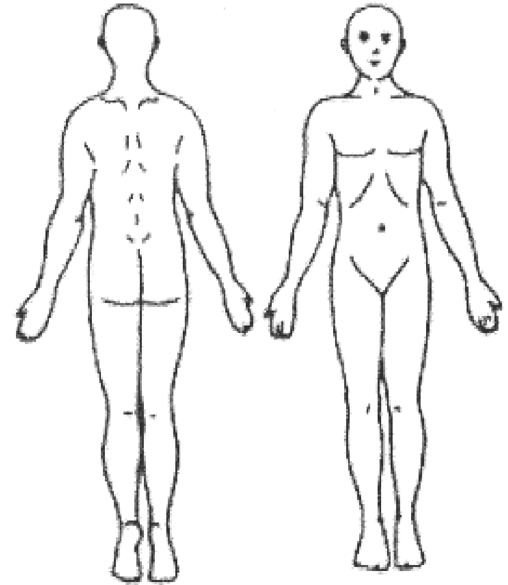
Patient Name: ___________________________________ Date:________________

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

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

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT





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:

Are you insured? ☐ **Yes** ☐ **No**

Company: ____

If you have a Secondary Insurance, Please list:____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN AGREEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST MY MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT ANY FEES ASSOCIATED WITH THE COLLECTION OF AN OVERDUE BILL ARE MY RESPONSIBILITY. I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED THE CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient Print Name: ____ **Date:** ______________

Patient's Signature: ____ **Date:** ______________