

# 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

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Sex: Male / Female  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Country: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Status:  Single  Married  Divorced  Widowed  Separated Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_

## 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.

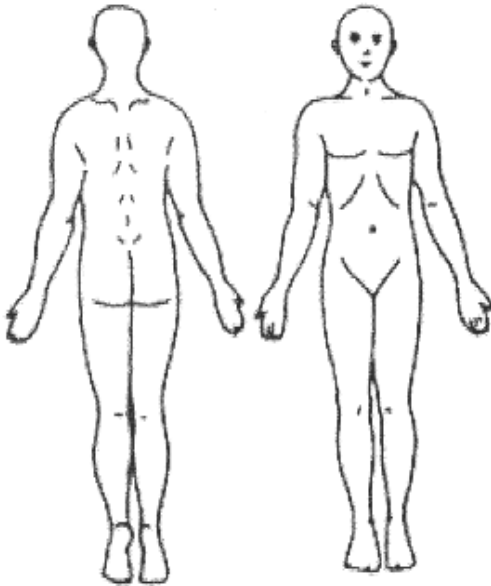
**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**



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: \_\_\_\_\_  
Have you seen other doctors for THIS CONDITION?  Yes  No  
If yes, Who? (Name) \_\_\_\_\_



Type of Treatment: \_\_\_\_\_ Were you satisfied with the results of your treatment?  Yes  No

Explain: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

**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?

Do you wear any of the following?  Heel Lifts  Innersoles  Arch Supports  Orthotics  Other \_\_\_\_\_

**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       daytime drowsiness       fatigue       fever       night sweats  
 weight gain       weight loss       other:

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness       blurred vision       cataracts       change in vision       double vision  
 eye pain       field cuts       glaucoma       itching       photophobia  
 tearing       glasses       contact lenses       other:

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding       dentures       difficulty swallowing       discharge       dizziness  
 ear drainage       ear pain       fainting       frequent sore throats       headaches  
 hearing loss       history of head injury       hoarseness       loss of sense of smell       nasal congestion  
 nosebleeds       postnasal drip       rhinorrhea (runny nose)       sinus infections       snoring  
 sore throat       tinnitus (ringing in ears)       TMJ problems       other:

**Respiration:**  I DENY having any of the symptoms or problems listed below.

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

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

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

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

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

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

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

**Male:**  I DENY having any of the symptoms or problems listed below.

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

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

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

**Skin:**  I DENY having any of the symptoms or problems listed below.

- changes in nail texture     changes in skin color     hair growth     hair loss     hives
- history of skin disorders     itching     paresthesias     rash     skin lesions / ulcers
- varicosities     other:

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- dizziness     facial weakness     headache     limb weakness     loss of consciousness
- loss of memory     numbness     seizures     sleep disturbance     slurred speech
- stress     strokes     tremor     unsteadiness of gait     loss of balance
- other:

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

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

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- anaphalaxis     food intolerance     itching     nasal congestion     rash
- sneezing     other:

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- anemia     bleeding     blood clotting     blood transfusion     bruising easily
- fatigue     lymph node swelling     other:

**PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
 Were you satisfied with your care?  Yes  No. Why? \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

\_\_\_\_\_  
\_\_\_\_\_

**Females ONLY: Mark all that apply below.**

- I AM:     currently pregnant     NOT pregnant     unsure
- Past Pregnancy History:  C-section     vaginal delivery     miscarriage

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

- back injury                       broken bones                       fall (severe)                       fracture
- disability (ies)                       head injury                       loss of consciousness                       joint injury
- laceration (severe)                       motor vehicle accident                       soft tissue injury                       other:

**Social History: Mark all that apply below.**

Tobacco:  Do not use Tobacco     Do not smoke cigars, cigarettes or pipe     Live with a smoker     Quit smoking  
 Smoke: # \_\_\_ per  Day     Week     Month;  Chew: # \_\_\_\_\_ cans per  Day     Week     Year

**Employment Information**

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Name of Supervisor: \_\_\_\_\_  
Business Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_

**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 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 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 understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic 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 Chiropractic Clinic 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 my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative 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 Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Consent to treat a Minor: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian or Spouse's Signature of Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_