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.** ☐ **Dr.** ☐ **Rev.** ☐ **Miss** ☐ **Prof.** ☐ **other:** _____

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III** ☐ **MD** ☐ **PhD** ☐ **DO** ☐ **Esq** ☐ **PA** ☐ **RN** ☐ **BSN** ☐ **other:** _____

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **Social Security #:** _____-_____-_____

Primary Language: ☐ **English** ☐ **French** ☐ **German** ☐ **Spanish** ☐ **other:** _____

Driver's License #: _____ **State:** _____

Blood Type: ☐ **A positive** ☐ **A negative** ☐ **B positive** ☐ **B negative** ☐ **AB positive** ☐ **AB negative** ☐ **O positive** ☐ **O negative**

Race: ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **Hispanic** ☐ **Multiracial** ☐ **Native American** ☐ **Other:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Eye Color: ☐ **blue** ☐ **brown** ☐ **green** ☐ **grey** ☐ **hazel** ☐ **other:** _____

Hair Color: ☐ **black** ☐ **blonde** ☐ **brown** ☐ **gray** ☐ **red** ☐ **white** ☐ **other:** _____

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

Title: ☐ **Miss** ☐ **Mrs.** ☐ **Ms.** ☐ **Master** ☐ **Mr.** ☐ **Dr.** ☐ **Prof.** ☐ **Rev.** ☐ **other:** _____

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III** ☐ **MD** ☐ **PhD** ☐ **DO** ☐ **Esq** ☐ **PA** ☐ **RN** ☐ **BSN** ☐ **other:** _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Email Address: _____

Birth Date: ____ /____/_____ **Social Security #:** _____-_____-_____

Home Phone: (_____) _____-_____ **ext** _____ **Cell Phone:** (_____) _____-_____ **ext** _____

Work Phone: (_____) _____-_____ **ext** _____ **Fax #:** (_____) _____-_____ **ext** _____

Employment Information

Business Name: _____

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Phone: (_____) _____-_____ **Fax #: (_____) _____-_____**

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

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

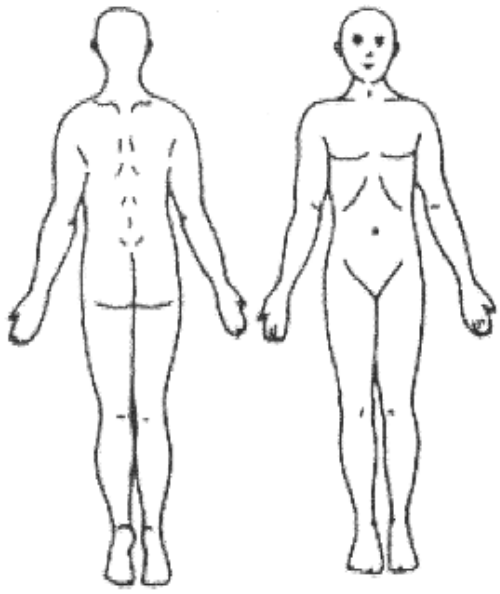
_____

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

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

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

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: _____ Were you satisfied with the results of your treatment? □ 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: _____
Were you satisfied with your care? □ Yes □ No. Why? _____

Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Other_____
For how long? _____ Were they prescribed by a doctor? □ Yes or □ No.

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?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	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	

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? ☐ yes or ☐ no.

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

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ alzheimers	☐ depression	☐ influenzal 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	

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 sugery	☐ joint replacement	☐ spinal fusion
☐ cardic catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Females ONLY: Ob/Gyn **Mark all that apply below.**

If you have been pregnant in the past, please fill in the appropriate information below.

_____Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____Number of C-sections	_____Number of vaginal deliveries
_____ Number of miscarriages	_____Number of terminated pregnancies
I… ☐ am currently pregnant	☐ am NOT currently pregnant

Menstrual History.

I… ☐ currently have menses.	☐ currently DO NOT have menses.
My menses… ☐ are regular.	☐ are NOT regular.
_____ Age of first menses	_____Age when metaphase began
Date of last menses: _____/_____/_____	

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:

Immunizations: **Please list the date(s)next to the immunization, if known.**

☐ adenovirus	☐ hepatitis C	☐ pertussis	☐ tuberculosis
☐ anthrax	☐ influenza	☐ pneumococcal	☐ tularemia

☐ botulism	☐ IPV (polio)	☐ pneumovax	☐ typhoid
☐ diphtheria	☐ Japanese encephalitis	☐ PPD (mantoux test- TB)	☐ varivax (chicken pox)
☐ DTaP (diphtheria, tetanus, pertussis)	☐ lyme disease	☐ rabies	☐ whooping cough (pertussis)
☐ flu	☐ measles	☐ rotavirus	☐ yellow fever
☐ haemophilus B	☐ meningococcal	☐ rubella	☐ other:
☐ hepatitis A	☐ MMR	☐ smallpox	
☐ hepatitis B	☐ mumps	☐ tetanus	

Non-Drug Allergies: **Mark all that apply below.**

☐ adhesive tape	☐ eggs	☐ newsprint	☐ shellfish
☐ animals	☐ feathers	☐ nuts	☐ smoke
☐ bee sting	☐ food coloring	☐ peanuts	☐ soap
☐ chocolate	☐ latex	☐ perfumes	☐ soy
☐ dairy	☐ mold	☐ pollen	☐ wheat
☐ other:			

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

1. angioedema	3. GI disturbance	5. joint pain	7. shortness of breath
2. anaphylaxis	4. headache	6. rash	8. unspecified reaction

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: **Mark all that apply below.**

Alcohol: ☐ do not drink alcohol ☐ social consumption only ☐ drink the following regularly (mark below)
☐ beer ☐ liquor ☐ wine; quantity of _____ oz./glasses per ☐ day ☐ week ☐ month

My Dietary Intake consists mainly of the following: (mark all that apply)

☐ high fat	☐ high salt	☐ low fiber
☐ high fiber	☐ low calorie	☐ low salt
☐ high protein	☐ low carbohydrate	☐ low sugar

Mark the highest level of Education completed:

☐ pre-school	☐ high school	☐ college	☐ doctorate
☐ elementary school	☐ high school graduate	☐ college graduate	☐ graduate school
☐ middle school	☐ GED	☐ associates degree	☐ graduate degree
☐ vocational school	☐ high school – incomplete	☐ bachelors degree	☐ other: _____

Substance: ☐ never used illegal drugs ☐ has not used illegal drugs since _____ .
☐ never used IV drugs ☐ used illegal drugs for _____ (how long?)

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

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: _____

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