CARABASI CHIROPRACTIC CENTER

Confidential Patient Health Record

Date:____________________ ID No.__________________

PERSONAL HISTORY

Full Name:____ Address:____

City:____ State:_________________ Zip Code:_______________

Home Phone:______________________________________ Date of Birth:________________Age:_______Sex:___M___F

Cell Phone:_______________________________________ E-mail Address:_______________________________________

Social Security #:__________________________________

Check One: ___ Married ___ Single ___ Widowed ___ Divorced ___ Separated

Business Employer: ________________________________ Type of Work:______________________________________

Business Phone:___________________________________

Name of Spouse/Partner:____________________________

Partner's Employer (if insured through Partner):____

Partner's Type of Work:______________________________ Partner's Business Phone:______________________________

Name and Ages of Children:____

Who can we thank for referring you? (How did you hear about us?)____

Name of Emergency Contact:________________________ Emergency Contact Phone:___________________________

Who is Responsible for Your Bill, You and ___ Spouse/Partner ___ Worker's Comp ___ Auto Insurance ___ Medicare

___ Personal Health Insurance (Name) ___________________________ Member ID#:_________________________

Insured Person's Name: ______________________________ Insured's Date of Birth:________________________________

CURRENT HEALTH CONDITION

Unwanted Health Condition (Reason for Visit): ____

Other Doctors Seen For This Condition: ___ Yes ___ No Who? ____

Type of Treatment:__________________________________ Results: ____

When did this Condition Begin?______________________ Has This Condition Occurred Before?: ___ Yes ___ No

Condition result of an Accident?___ No ___ Yes

If Yes, (select accident type): ___ On The Job ___ Auto Accident ___ Home Injury ___ Fall ___ Other:___________________

Date of Accident:____________________________________ Time of Accident:____

If Work Related, Have You Made A Report of Your Accident To Your Employer: ___ Yes ___ No

Medications you now take: ___ Nerve Pills ___ Pain Killers/Muscle Relaxers ___ Blood Pressure ___ Insulin

List Any Other Medication:____

Do You Wear a Shoe Lift? ___ Yes ___ No

Do You Suffer From any Condition Other Than That Which You Are Now Consulting Us? ___Yes ___No

Explain:____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ___ Appendectomy ___ Tonsillectomy ___ Gall Bladder ___ Hernia ___ Back Surgery

___ Broken Bones ___ Other: ____

Major Accidents or Falls:____

Hospitalization (Other Than Above)____

Previous Chiropractic Care: ___ Yes ___ No

Doctor's Name: ___________________________ Location:____________________________

Approximate Date of Last Chiropractic Visit:___________________________

Reason For Changing:____

Below are a list of diseases which may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect your overall course of care:

CHECK CNY OF THE FOLLOWING DISEASES YOU HAVE HAD:

___ Pneumonia
___ Pneumatic Fever
___ Polio
___ Tuberculosis
___ Cancer
___ Anemia
___ Measles

___ Mumps
___ Small Pox
___ Chicken Pox
___ Diabetes
___ Whooping Cough
___ Heart Disease
___Thyroid

___ Influenza
___ Pleurisy
___ Arthritis
___ Epilepsy
___ Mental Disorders
___ Lumbago
___ Eczema

INTAKE:

___ Coffee
___ Tea
___ Soda
___ Alcohol
___ Cigarettes
___ White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE:

___ Low Back Pain
___ Pain between Shoulders
___ Neck Pain
___ Arm Pain
___ Joint Pain/Stiffness
___ Walking Problems
___ Difficult Chewing/Clicking Jaw
___ General Stiffness

NERVOIS SYSTEM CODE:

___ Nervous
___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___ Confusion/Depression
___ Convulsions
___ Cold/Tingling Extremities
___ Stress

GENERAL CODE:

___Fatigue
___ Allergies
___ Loss of Sleep
___ Fever
___ Headaches

GASTRO-INTESTINAL CODE:

___ Poor/Excessive Appetite
___ Excessive Thirst
___ Frequent Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Liver Problems
___ Gall Bladder Problems
___ Abdominal Cramps

GASTRO-INTESTINAL CODE (Cont.):

___Gas/Bloating after Meals
___ Heartburn
___ Black Bloody Stool
___ Colitis

GENITO-URINARY CODE:

___ Bladder Trouble
___ Painful/Excessive Urination
___ Discolored Urine

C-V-R CODE:

___ Chest Pain
___ Short Breath
___ Blood Pressure Problems
___Irregular Heartbeat
___ Heart Problems
___Lung Problems/Congestion
___ Ankle Swelling
___ Stroke

EENT CODE:

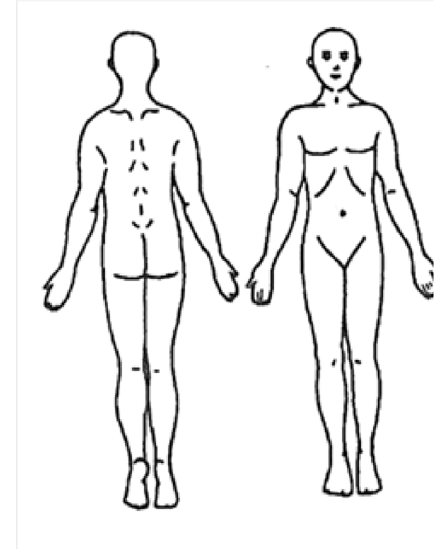
___ Vision Problems
___ Dental Problems
___ Ear Aches
___ Sore Throat
___ Hearing Difficulty
___ Stuffed Nose

FAMILY HISTORY

The following members have a same or similar problem as I do:

___ Mother
___ Father
___ Brother
___ Sister
___ Spouse/Partner
___ Child

Mark any AREA(s) of:
Pain, Numbness, Discomfort:



MALE ONLY:

___ Prostate/Sexual Dysfunction
___ Other Problems
___ ________________________
___ ________________________
___ ________________________

FEMALE ONLY:

___ Menstrual Irregularity
___ Menstrual Cramps
___ Vaginal Pain/Infection
___ Breast Pain/Lumps
___ Other Problems
___ ________________________

Last Period: ________________

Are You Pregnant?
___ Yes ___ No ___ Unsure

Take Birth Control/Hormones?
___ Yes ___No

DO NOT WRITE BELOW THIS LINE

ANALYSIS:____________________________________
DIAGNOSIS:___________________________________
Patient Accepted: ___ Yes ___ No ___ Referred

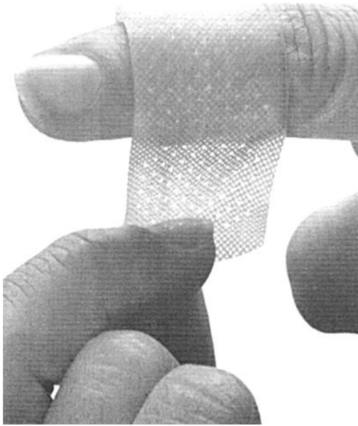
____
Doctor's Signature

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please Check the type of care desired so that we may be guided by your wishes whenever possible.

___ Relief Care ___ Corrective Care ___ I want the doctor to select the type of care appropriate for my condition

Date:__________________________ Signature: ____



Relief Care is that necessary to get rid of your symptoms or pain but not the cause of it. This is the same as drying a floor that was getting wet from a leak but not fixing the floor.

Corrective Care differs from relief car in that the goal is to get rid of the symptoms or paid while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

If you need treatment for an accident related injury, please fill out the Accident Form. Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Carabasi Chiropractic Center 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 Carabasi Chiropractic Center will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctors of Carabasi Chiropractic Center to treat my condition as they deem appropriate.

Patient's Signature: ____ Date:________________________

Consent to Treat a Minor, Parent/Guardian Name: ____

Parent/Guardian Signature Authorizing Care: ____ Date:________________________