# CONFIDENTIAL PATIENT HEALTH RECORD

Today's Date ____/____/______

Russ C. Redd, DC
(919) 556-2014
1269 South Main Street
Wake Forest, NC 27587

***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: (_____) ______-_________ Work Phone: (_____) ______-_________ ext ____

Cell Phone: (_____) ______-_________ Fax #: (_____) ______-_________

Email Address: _________________________________ Spouses Name: ________________________________

Children (Names and Ages): _______________________________________________________________________

## *Emergency Contact*

Last:_______________________________ First:______________________________ Middle:____________________

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _________________________

Home Phone: (_______) _______-__________ Cell Phone: (_______) _______-__________

Work Phone: (_______) _______-__________ ext ______

## *Employment Information*

Business Name: __________________________________________________________________________________

Work Phone: (_____) ______-_________ ext ____ Fax #: (_____) ______-_________

Employer's Email Address: __________________________________________________________________________

Occupation/Job Title: ______________________________ Job Description ________________________________

## *Current Health Condition*

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

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

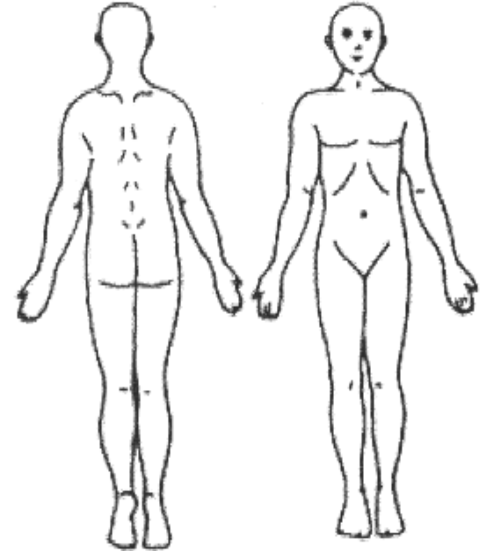
Doctor Signature ____________________________________ Date __________________

Patient Name: ___________________________________ Date:________________

**Please Label On The Diagram The Area Of Discomfort**

**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*



**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, please 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?**

**______________________________________________________**

**______________________________________________________**

**Rate your pain level. 0-10 Scale 0 being no pain, 10 being severe pain.**

**Active 0 1 2 3 4 5 6 7 8 9 10 Resting 0 1 2 3 4 5 6 7 8 9 10**

**Current Height _______ Current Weight_________**

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**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 |

Doctor Signature ________________________________ Date ________________

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 | |

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Doctor Signature ________________________________ Date ________________

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.**

Doctor Signature ______________________________ Date _______________

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/Injuries:* 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: __________________ Employment: ______________________________

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 #: ________________________________________________

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

**Patient Name (Print):** ________________________________________________ **Date:** _______________
**Patient's Signature:** _________________________________________________ **Date:** _______________

Doctor Signature ________________________________ Date ________________