Confidential Patient Health Record

New Client – Strong Chiropractic S.C.

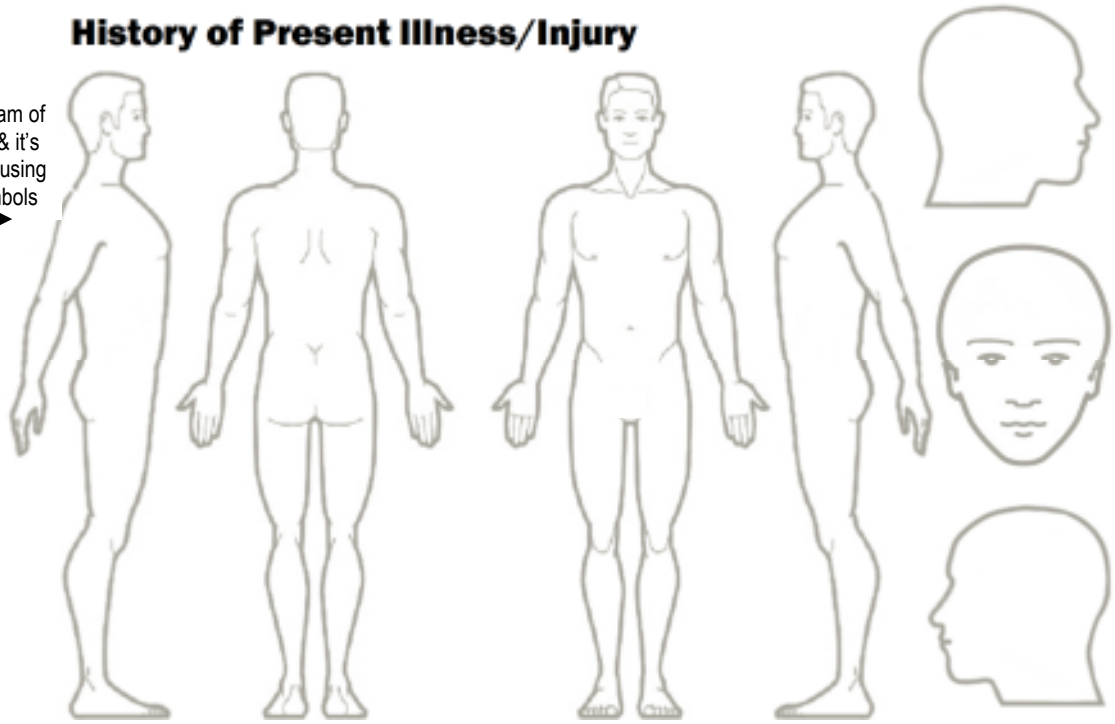
New Patient ☐
Reactivate ☐
Other ☐

Name _____ Date _____
Street Address / PO Box _____ Home Ph _____
City / State / Zip _____ Mobile Ph _____
Social Sec No _____ Work Ph _____
Employer Name _____ Birth Date _____
Marital Status _____ Email Address *(Below):*
Spouse's Name _____ _____
Names / Ages of Children _____
_____
Emergency Contact _____ Relationship _____ Phone _____
Who Is Your Medical Doctor? _____ Facility / City _____
How Were You Referred? ___My MD ___Ins. Plan ___Another Person ___Other _____

History of Present Illness/Injury

Symbol	For:
XXX	Burning Pain
((((	Aching Pain
0 0 0	Pins & Needles
- - - -	Numbness
: : : :	Sharp

Do a diagram of your pain & it's location(s) using these symbols ↔



Please Complete

____Constant
____Comes & Goes

____Getting Better
____Getting Worse
____Stayed the Same

Better:		Worse:
_____	AM	_____
_____	Mid Day	_____
_____	PM	_____

Comments Regarding Diagram: _____

_____

_____

_____

Rate Your Level Of Discomfort:

Enter the number that best represents your level of discomfort as it applies to you. **"0"** is no discomfort; **"10"** is the most severe.

0	1	2	3	4	5	6	7	8	9	10
None *No Complaints*		**Mild** *Forgotten With Activity*		**Moderate** *Interferes With Activity*		**Limiting** *Prevents Full Activity*		**Intense** *Preoccupied With Seeking Relief*		**Severe** *No Activity Possible*

Neck (Rate 0-10)	**Mid Back** (Rate 0-10)	**Low Back** (Rate 0-10)	**Other:**_____	**Other:**_____	**Other:**_____
Now: _____	Now: _____	Now: _____	Now: _____	Now: _____	Now: _____
Best: _____	Best: _____	Best: _____	Best: _____	Best: _____	Best: _____
Worst: _____	Worst: _____	Worst: _____	Worst: _____	Worst: _____	Worst: _____
Usual: _____	Usual: _____	Usual: _____	Usual: _____	Usual: _____	Usual: _____

What Makes The Condition Better?	What Makes The Condition Worse?
Head/Neck_____	Head/Neck_____
Mid Back _____	Mid Back _____
Low Back _____	Low Back _____
Shoulder, Arm, Hand _____	Shoulder, Arm, Hand _____
Hip, Leg, Foot _____	Hip, Leg, Foot_____
Other:	Other:

Indicate Your Ability To Perform The Following Activities: *Please Use The Codes As Shown Below*

H = HAVEN'T TRIED **N** = NORMAL **D** = DIFFICULT **U** = UNABLE **L** = LIMITED **P** = PAINFUL

1_____Lying on Back	6 _____Using Stairs/Ladder	11_____Sexual Activity	16_____Walking
2_____Lying on Sides	7 _____Gripping	12_____Getting In/Out of Car	17_____Standing
3_____Lying on Stomach	8 _____Pushing/Pulling	13_____Sitting/Driving/Riding	18_____Bending Forward
4_____Turning Over In Bed	9 _____Reaching	14_____Using a Computer	19_____Lifting
5_____Stooping	10_____Dressing Self	15_____Kneeling	20_____Cough-Sneeze-Grunt

General Questions:

Yes **No**

___ ___ Does the discomfort interfere with your sleep? How many times does it wake you up?_____

___ ___ Do you sleep with a pillow? How Many _____ Type: Foam___ Polyester Fill___ Feather___

a. Where do you place them?_____

b. What position(s) do you sleep in? _____

c. How old is your mattress? _____

___ ___ Does using HEAT affect the pain? How?_____

___ ___ Does using COLD affect the pain? How?_____

___ ___ Do you wear a heel lift? Which side? _____Right _____Left

___ ___ Do you wear orthotics?

___ ___ Have you had x-rays of the problem areas done?

a. Body parts? _____

b. When? _____

c. Facility? _____

Females: Are you pregnant? ____Yes ____No

Projected Due Date? _____ Doctor: _____

Date of last gynecological exam? _____ Breast exam? _____

Males: Date of last prostrate and testicular exam? _____

Neck & Headache Questions:

Yes **No**

___ ___ Difficulty turning head? _____Left _____Right _____Up _____Down

___ ___ Do you hear grating / cracking sounds? _____Neck _____Jaw _____Temples _____Scalp area

___ ___ Do you "crack" your own neck?

___ ___ Do you get pain or cracking / clicking in your jaw?

___ ___ Is there a family history of headaches?

___ ___ Do you have nausea, vomiting, visual disturbances, altered hearing, ringing in ears or loss of balance?

___ ___ Do you experience pain or pressure behind your eye(s)? _____Right _____Left

Frequency of headaches: _____ Per_____

Date of last eye exam? _____ Any Rx changes? _____Yes _____No

Low Back Pain Questions:

Yes **No**

___ ___ Does pain radiate to the abdomen and/or groin areas?

___ ___ Any impairment of bowel or bladder functions? Explain_____

___ ___ Was there a feeling of ripping or tearing?

___ ___ Do you try to "crack" your own back?

Past Medical History:

How many times have you had the condition that you are seeing us for today? ___ Never ___ 1-3 Times ___4 or more

Yes **No**

___ ___ **Do you suffer from any other health conditions?** *(Check all that apply.)*

_____Diabetes _____High blood pressure _____High cholesterol _____Asthma _____IBS/ Colitis

_____Cancer _____Arthritis _____Infertility issues _____Others_____

Yes **No**

___ ___ **Have you ever seen a chiropractor before?**

a. When was the last time you were seen?_____ Dr's Name_____
b. For what problems?_____ Were you helped?_____
c. How often were you being seen?_____Why did you leave?_____
d. List any other chiropractors you've seen in the past: *(Use more paper if needed.)*

Date	Dr. Name	Condition(s)	Why did you leave?

Yes **No** **Have you ever seen a medical doctor for your current condition before?** *(Use more paper if needed.)*

___ ___

Date	Dr. Name	Condition(s)	Results – *Check Which Applies*			
				Total Recovery		Complications
				Total Recovery		Complications
				Total Recovery		Complications

Yes **No** *(Use more paper if needed.)*

___ ___ **Do you have any allergies?** If so, to what? _____

Have you attempted any self-care remedies to alleviate your condition? (E.G. topical ointments or home medical equipment such as braces/supports, cervical pillow, low back support belt, stretching, exercise, etc.?) If yes, what? _____

_____

Yes **No**

___ ___ **Are you currently taking any medications, over the counter drugs, supplements, herbs or vitamins?**

Please provide a list of what you are taking. *(Use more paper if needed.)*

Name of Drug: Prescription, Over-the Counter, Herb, .Vitamin, or Supplement	Strength *(Ex. Mg)* Dosage	Frequency	Reason	Is It Helping?		
				Yes	**No**	**Not Sure**

Yes **No**

___ ___ **Have you had any major illnesses, injuries, falls hospitalizations, auto accidents, and/or surgeries, etc?** Please describe below: *(Use more paper if needed.)*

Date	Dr. Name	Condition(s)	Results – *Check Which Applies*			
				Total Recovery		Complications
				Total Recovery		Complications
				Total Recovery		Complications
				Total Recovery		Complications
				Total Recovery		Complications
				Total Recovery		Complications

Social Health History:

Gender: ____Male ____Female **Student:** ____Part time ____Full-time School:_____

Recreational activities / Hobbies: _____

Yes **No**

___ ___ Do you exercise? How often? _____ In what way? _____

___ ___ Are you a smoker? How much? _____

___ ___ Do you drink water? How much & often? _____

___ ___ Do you drink caffeine? How much & often? _____

___ ___ Do you drink alcohol? How much & often? _____

Family Health History:

List any current or past health conditions of your family members. If deceased at what age and from what?

Mother_____

Father _____

Brothers & Sisters _____ How many? ____

Children_____How many? ____

System Review Questions:

Have you had any problems with any of the following areas now or in the past?
Please mark "**Y**" for yes and "**N**" for no for each of the following items.

1. _____**Eyes** *(glasses, contacts, cataracts, glaucoma, etc.)*
2. _____**Ears, mouth, nose, throat** *(hearing loss, sinus, etc.)*
3. _____**Cardiovascular** *(heart, high BP, high cholesterol, etc.)*
4. _____**Respiratory** *(lungs, breathing, asthma, COPD, etc.)*
5. _____**Neurological** *(nerve issues, weakness, numbness, etc.)*
6. _____**Endocrine** *(thyroid, hormonal imbalances, liver, etc.)*
7. _____**Gastro-Intestinal** *(acid reflux, gall bladder, IBS, ulcers, etc.)*
8. _____**Genito-Urinary** *(male-female reproduction, kidneys, bladder, etc.)*
9. _____**Musculoskeletal** (breaks, arthritis, osteoporosis, discs, etc.)
10. _____**Skin** *(rashes, skin cancer, dryness, psoriasis, eczema, hair, etc.)*
11. _____**Psychiatric** *(anxiety, depression, bi-polar, ADD/ADHD, etc.)*
12. _____**Others:**_____

Authorization

I, the undersigned, acknowledge that all of the above statements in this form are true to the best of my knowledge. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: _____ Date:_____

Guardian Signature:_____ Date:_____

D.C. Signature: _____ Date:_____

For Office Use Only

Level of Present Illness/Injury: ____ Brief ____ Extended

Nature of Presenting Problem: ____Minimal ____Self Limited ____Low Severity ____Moderately Severe ____High Severity

Level of Past Medical/Social/Family History: ____NA ____Pertinent *(1 of Above Histories)* ____Complete *(2 or 3 of Above Histories)*

Level of System Review: ____Problem Pertinent *(1 System)* ____Extended *(2-9 Above Systems)* ____Complete *(10+ Above Systems)*

Level of Overall History: ____Problem Focused ____Expanded Problem Focused ____Detailed ____Comprehensive

Office Notes:

_____

_____

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