Confidential Patient Health Record

***Today's Date*: ____/_____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Insurance Plan** ☐ **Dr.** _____ ☐ **Phone Book** ☐ **Weekly Mailer** ☐ **Times News** ☐ _____

Personal Information

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

Birth Date: ____ /____/_____ **Age:** _____ **Sex: Male / Female** **SSN:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** **Spouses Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email Address:** _____@_____

Emergency Contact

Last: _____ **First:** _____ **Relation:** _____ **Phone:** _____ **Cell:** _____

Employment Information

Business Name: _____ **Phone:** _____

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

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):**_____

Ins Carrier: _____ **Policy#**_____ **Group#**_____ **Carrier Phone**_____

Insured's Name:_____ **Policy Holder's Date of Birth:** _____ **PCP:** _____

Current Health Condition

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

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

When did this Condition BEGIN? _____
Has it ever occurred before? ☐ **Yes** ☐ **No.** **When?** _____

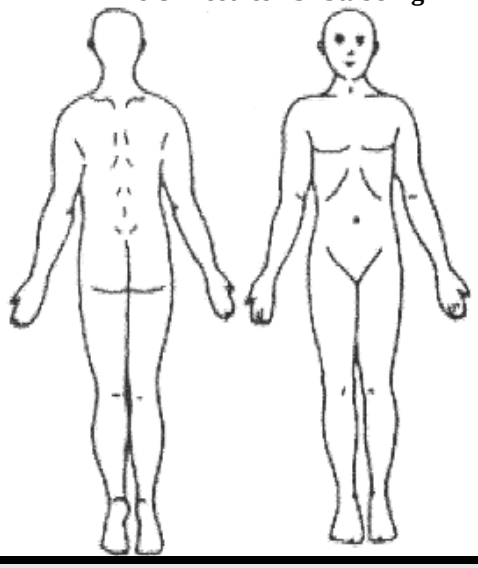
Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____
_____

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

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



Family History: ***List* all relevant specific conditions:**

Family Member	Condition

Previous Chiropractic Care: ☐ I have not previously seen a Chiropractor

Doctor's Name: _____ **Location:** _____ **Date of Last Visit:** _____

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

Previous Care for this Condition: ☐ **I have not previously seen a doctor for this condition**

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: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking.**

Medication	For What Condition?	Medication	For What Condition?

Illness(es) Injury(ies) Surgery(ies): **List all WITH DATES.** **Doctor: contributory? ☐yes ☐no**

_____
_____
_____

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 any			*Eyes/Vision:* ☐ I DENY any		
☐ chills	☐ night sweats		☐ blindness	☐ corrective lenses	☐ glaucoma
☐ daytime drowsiness	☐ weight gain		☐ blurred vision	☐ double vision	☐ itching
☐ fatigue	☐ weight loss		☐ cataracts	☐ eye pain	☐ photophobia
☐ fever			☐ change of vision	☐ field cuts	☐ tearing

Ears, Nose and Throat: ☐ I DENY any			*Cardiovascular:* ☐ I DENY any		
☐ bleeding	☐ head injury	☐ postnasal drip	☐ angina (chest pain)	☐ high bp	☐ swelling of legs
☐ dentures	☐ tinnitus	☐ runny nose	☐ claudication (leg pain)	☐ low bp	☐ ulcers
☐ discharge	☐ hearing loss	☐ sinus infections	☐ heart problem	☐ palpitations	☐ varicose veins
☐ dizziness	☐ hoarseness	☐ snoring	☐ orthopnea (difficult breathing lying down)		
☐ ear drainage\pain	☐ loss of smell	☐ sore throat(often)	☐ paroxysmal nocturnal dyspnea(waking at night w/ shortness of b		
☐ fainting	☐ nasal congestion	☐ TMJ problems	☐ shortness of breath(with exertion or exercise)		
☐ headaches	☐ nosebleeds	☐ difficult swallowing			

Gastrointestinal: ☐ I DENY any			*Female:* ☐ I DENY any		
☐ abnormal stools	☐ diarrhea	☐ jaundice	☐ birth control	☐ frequent urination	☐ urine retention
☐ abdominal pain	☐ heartburn	☐ nausea	☐ breast lumps/pain	☐ hormone therapy	☐ vaginal bleeding
☐ belching	☐ hemorrhoids	☐ rectal bleeding	☐ burning urination	☐ pregnancy	☐ vaginal discharge
☐ constipation	☐ indigestion	☐ vomiting	☐ cramps	☐ irregular menstruation	

Respiration: ☐ I DENY any			*Male:* ☐ I DENY any		
☐ cough	☐ shortness of breath	☐ wheezing	☐ burning urination	☐ frequent urination	☐ prostate problems
☐ coughing up blood	☐ sputum production		☐ erectile dysfunction	☐ hesitancy/dribbling	☐ urine retention

Endocrine: ☐ I DENY any			*Skin:* ☐ I DENY any		
☐ cold intolerance	☐ excessive thirst	☐ heat intolerance	☐ hives	☐ paresthesias	☐ skin disorders
☐ diabetes	☐ goiter	☐ hair growth change	☐ itching	☐ rash	☐ skin lesions/ulcers
☐ excessive appetite	☐ hair loss	☐ voice changes	☐ nail texture change	☐ skin color change	☐ varicosities

Nervous System: ☐ I DENY any			*Psychological:* ☐ I DENY any		
☐ dizziness	☐ numbness	☐ stress	☐ anhedonia	☐ bi-polar disorder	☐ insomnia
☐ facial weakness	☐ seizures	☐ strokes	☐ anxiety	☐ confusion	☐ memory loss
☐ limb weakness	☐ slurred speech	☐ tremor	☐ appetite change/loss	☐ convulsions	☐ mood change
☐ loss of consciousness	☐ sleep problems	☐ loss of balance	☐ behavioral change	☐ depression	

Allergy: ☐ I DENY any			*Hematologic:* ☐ I DENY any		
☐ anaphalaxis	☐ acute nasal congestion	☐ sneezing	☐ anemia	☐ blood clotting	☐ bruising easily
☐ food intolerance	☐ chronic nasal congestion		☐ bleeding	☐ blood transfusion	☐ lymph node swellin

I understand and agree that a history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes at my request. My case may not be accepted for treatment at this clinic. If it is believed that I may respond to care, additional services may be recommended and I will be advised of applicable cost. The information provided is correct to the best of my knowledge.

Patient(Guardian) Signature: _____ Date: _____