PATIENT HEALTH RECORD

Chiropractic First Wellness Center, 3257 19th St Ste 1, Rochester, MN 55901

About the Patient

Name_____

Address_____

City_____ State_____

Zip _____Home phone _____

Birth date _____ Cell Phone_____

E-mail_____

Best Contact Method (CIRCLE ONE) Home Cell E-mail

Age _____ Gender _____ Number of children _____

Race (CIRCLE ONE) White Black/African American Hispanic

American Indian Asian Other:_____

Ethnicity (CIRCLE ONE) Hispanic/Latino Not Hispanic/Latino

Language (CIRCLE ONE) English Other_____

Employer_____

Work phone _____

Type of work _____

Marital Status _____

Insurance Carrier_____

Last four of Social Security #_____

How did you hear about us (CIRCLE ONE) Newspaper Internet

Yellow Pages Referral by:_____

Emergency Contact

Name_____ Phone _____

Relationship (CIRCLE ONE) Spouse Child Other Family Friend

Employer_____ Phone _____

Chiropractic History

Previous Chiropractor? _____

Was it a positive experience? _____

Previous physician or therapist? _____

Was it a positive experience? _____

Have other family members seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

Name of primary Physician _____

May we contact them?_____

Reason for this Visit

Main complaint _____

When did this condition begin? _____

Rate the pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

Has this condition:

☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with:

☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

When is it best? _____ Worst? _____

Has this condition occurred before? ☐ Yes ☐ No

Please explain _____

Type of Pain: ☐ None ☐ Burning ☐ Aching ☐ Sharp

☐ Radiating ☐ Tight ☐ Numbing ☐ Shooting ☐ Tingling

What helps the pain level? _____

How often is pain present?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Is the condition related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall

☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

If job related, have you made a formal report to your employer?

☐ Yes ☐ No

Please explain _____

Height _____ Weight _____ B/P _____

Health Habits

PLEASE CIRCLE ANSWER BELOW:

Do you smoke? Yes No Former

Do you drink alcohol? None Casual Moderate Heavy

How many Cups of Caffeine per Day? 0 1-3 3-6 6+

Do you Exercise? Never Daily Weekly Walk Run Swim

Do you wear:

☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Health History

Please check each of the diseases or conditions that the patient has now or has had in the past.

ALLERGIES_____ Surgeries _____

☐ Ankle / leg pain	☐ Anorexia / Bulimia	☐ Appendicitis	☐ Arm / Hand pain	☐ Arthritis
☐ Asthma	☐ Bleeding disorder	☐ Broken bones	☐ Cancer	☐ Chest pain
☐ Heart defect	☐ Depression / other	☐ Diabetes Type_____	☐ Difficulty breathing	☐ Dizziness
☐ Emphysema	☐ Eye / Vision problems	☐ Fainting	☐ Fatigue	☐ Fibromyalgia
☐ Frequent colds	☐ Gout	☐ Headaches / Migraines	☐ Hearing problems	☐ Hepatitis / Liver Disease
☐ Hernia	☐ Herniated Disc	☐ High Blood Pressure	☐ High Cholesterol	☐ Hip pain
☐ Jaw Pain	☐ Joint stiffness	☐ Low Back pain	☐ Mid Back pain	☐ Multiple Sclerosis
☐ Neck Pain	☐ Neurological Disorder	☐ Numbness	☐ Osteoporosis	☐ Pacemaker / Defibrillator
☐ Parkinson's Disease	☐ Prostate problems	☐ Rheumatoid	☐ Scoliosis	☐ Seizure Disorder
Shingles	☐ Shoulder pain	☐ Major Weight change	☐ Sinus problems	☐ Sleep disorder
☐ Spinal Cord injury	☐ Sprain / Strain	☐ Stroke / Heart Attack	☐ Ulcer/s	

Other _____

Current Medications

Med:_____ Dose: _____
Med:_____ Dose: _____
Med:_____ Dose: _____
Med:_____ Dose: _____

Vitamins and Supplements: _____

_____

Medication allergies: _____

_____

For Women

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No
Do you experience painful periods?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No
Do you have breast implants?	☐ Yes	☐ No

Notice Of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 3 business days following a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and our staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____ Date:_____