

Confidential Patient Health Record

Today's Date: ___/___/___

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 Ht ___' ___"
 Marital Status: Single Married Widowed Divorced Wt _____ lbs.
 Address: _____ Apt # _____
 City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ ext _____
 Cell Phone: (____) _____ - _____
 Email Address: _____
 Spouses Name: _____ #Children _____

Emergency Contact

Last: _____ First: _____ Middle: _____
 Relationship: Spouse Relative Friend Other _____
 Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
 Work Phone: (____) _____ - _____ ext _____

Employment Information

Business Name: _____
 Phone: (____) _____ - _____ ext _____ Fax #: (____) _____ - _____
 Occupation/Job Title: _____

REASON FOR YOUR VISIT TODAY:

Use the letters **BELOW** to indicate the **TYPE** and **LOCATION** of your conditions right now.

**Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing**

When did this Condition **BEGIN**? ____/____/____

Have you had any **X-rays/MRI**? yes__ no __

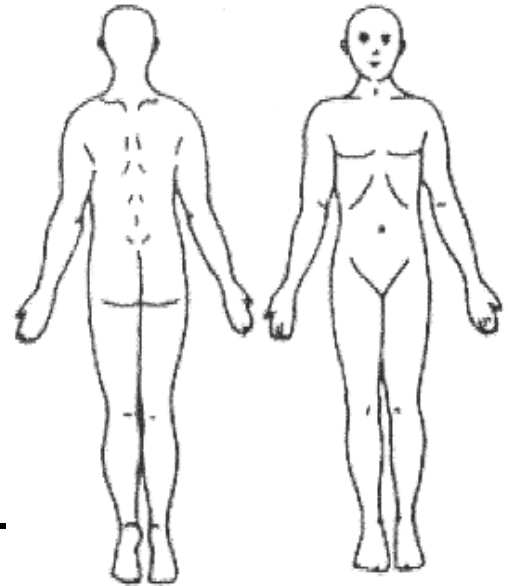
When?_____ Where?_____

Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Has it ever occurred before? Yes No. When? _____



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: CHECK all the symptoms below that apply to you. If NONE apply check here

- chills
- fatigue
- night sweats
- weight loss
- daytime drowsiness
- fever
- weight gain

Eyes/Vision: CHECK all the symptoms below that apply to you. If NONE apply check here

- blindness
- change in vision
- field cuts
- photophobia
- blurred vision
- double vision
- glaucoma
- tearing
- cataracts
- eye pain
- itching
- wear glasses/contacts

Ears, Nose and Throat: CHECK all the symptoms below that apply to you. If NONE apply check here

- 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
- rhino rhea (runny nose)
- TMJ problems
- discharge
- frequent sore throats
- loss of sense of smell
- sinus infections
- dizziness
- headaches
- nasal congestion
- snoring

Respiration: CHECK all the symptoms below that apply to you. If NONE apply check here

- asthma
- coughing up blood
- sputum production
- cough
- shortness of breath
- wheezing

Cardiovascular: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> swelling of legs |
| <input type="checkbox"/> claudication (leg pain/ache) | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) | |

Gastrointestinal: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool caliber | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> cramps | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy | <input type="checkbox"/> urine retention | |

Male: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | |
|---|---|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention |

Endocrine: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

Skin: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> hair growth | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash | |

Nervous System: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> limb weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures | <input type="checkbox"/> stress | <input type="checkbox"/> unsteadiness of gait/ loss of balance |
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of memory | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |

Psychologic: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion | <input type="checkbox"/> insomnia | |

Allergy: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

Hematologic: CHECK all the symptoms below that apply to you. If NONE apply check here

- | | | | |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> blood clotting | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue | |

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. If NONE check here

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): CHECK all health conditions. If NONE check here

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hay fever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spinal bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

Adult Illness(es): CHECK all health conditions. If NONE check here

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> depression | <input type="checkbox"/> influenza pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Surgery (ies): CHECK and DATE all Surgical Procedures. If NONE check here

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Injury (ies): CHECK and DATE all Injuries that apply. If NONE check here

- back injury
- broken bones
- disability (ies)
- fall (severe)
- fracture
- head injury (loss of consciousness)
- head injury (no loss of consciousness)
- industrial accident
- joint injury
- laceration (severe)
- motor vehicle accident
- soft tissue injury (mild)
- soft tissue injury (moderate)
- soft tissue injury (severe)
- other:

Family History: Please list below any Pertinent health conditions that a family member has/had.

General Family **Health Condition**

- Father** alive deceased
- Mother** alive deceased
- Son (s)** alive deceased
- Daughter (s)** alive deceased
- Brother (s)** alive deceased
- Sister (s)** alive deceased

Insurance Information:

Who Is Responsible For Your Bill? YOU and... (mark appropriate box(es)) Myself ONLY

Spouse Worker's Comp Auto Insurance Medicare Other (be specific): _____

Personal Health Insurance Carrier: _____ **Health ID Card #:** _____

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 #: _____ **Adjuster's Phone #** _____

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

Patient Print Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

OFFICE USE ONLY

BP _____ Pulse _____ Temp _____ HR _____

X-rays _____ Exam _____

DIAGNOSIS

Cervical 839.08__ Thoracic 839.21__
Lumbar 839.20__ Sacroiliac 839.42__

