

**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 **SSN:** \_\_\_\_\_

**Marital Status:**  Single  Married  Widowed  Divorced  Separated

**Address:** \_\_\_\_\_ **Apt #** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Country:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_ **Fax #:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Spouses Name:** \_\_\_\_\_

**Children (Names and Ages):** \_\_\_\_\_

**Emergency Contact**

**Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

**Relationship:**  Spouse  Relative  Friend  Other \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **ext** \_\_\_\_\_

**Employment Information**

**Business Name:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Fax #:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Employer's Email Address:** \_\_\_\_\_

**Occupation/Job Title:** \_\_\_\_\_ **Job Description** \_\_\_\_\_

**Current Health Condition**

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

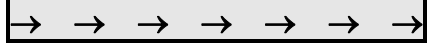
Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**



**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? \_\_\_\_\_

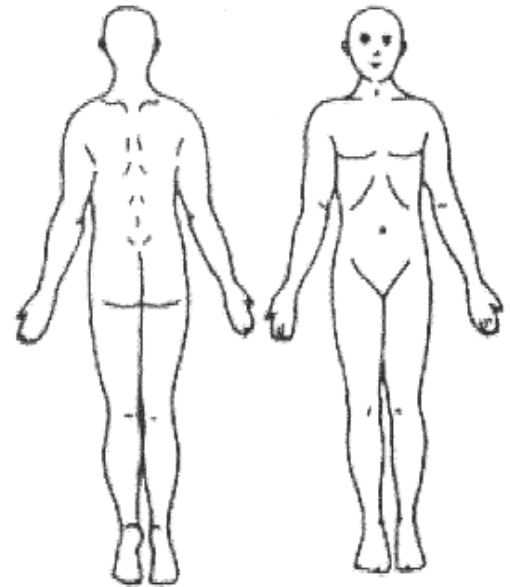
Is the Condition:  Auto Related  Job Related  Home Injury  
 Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

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?  
\_\_\_\_\_  
\_\_\_\_\_



**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

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |
|--|--|--|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |   |  |  |   |   |
|---|--|--|---|---|
| <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:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- |  |   |   |  |
|--|---|---|--|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |   |   |  |
|---|---|--|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |   |  |   |  |
|---|--|---|--|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |   |  |
|--|--|--|---|--|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <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:**  I DENY having any of the symptoms or problems listed below.

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <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         |  |

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 (discoïd)
- 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.**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- |  |   |   |  |
|--|---|---|--|
| <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"/> tonsilectomy        |
| <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): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> back injury      | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident        |
| <input type="checkbox"/> broken bones     | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild)     |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident                    | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe)    | <input type="checkbox"/> joint injury                           | <input type="checkbox"/> soft tissue injury (severe)   |
| <input type="checkbox"/> fracture         | <input type="checkbox"/> laceration (severe)                    | <input type="checkbox"/> other: _____                  |

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> 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: \_\_\_\_\_ 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 #: \_\_\_\_\_

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: \_\_\_\_\_