

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

First: _____ Middle: _____ Last: _____ Sex: Male / Female
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Status: Single Married Divorced Widowed Separated Birth Date: ___ / ___ / ___
Age: _____
Social Security #: _____ - _____ - _____ Fax #: (_____) _____ - _____
Driver's License #: _____ State: _____ Email Address: _____
Spouses Name: _____
Children (Names and Ages): _____

Emergency Contact

Name: _____ Phone Number: (_____) _____ - _____
Address: _____
Relationship: Spouse Relative Friend Other _____

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.

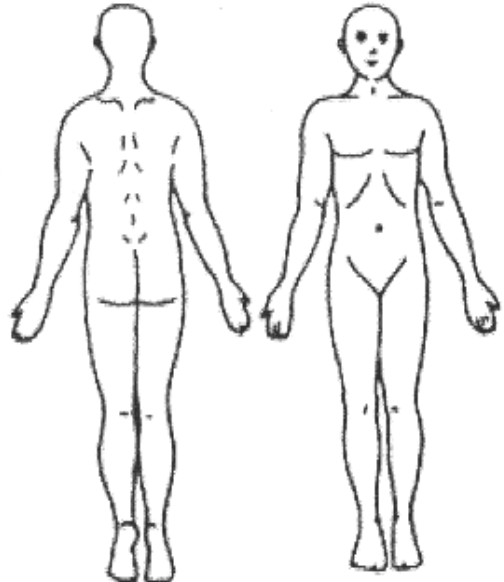
PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



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: _____
Have you seen other doctors for THIS CONDITION? Yes No
If yes, Who? (Name) _____



Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

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

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?

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

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 daytime drowsiness fatigue fever night sweats
 weight gain weight loss other:

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- blindness blurred vision cataracts change in vision double vision
 eye pain field cuts glaucoma itching photophobia
 tearing glasses contact lenses other:

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- bleeding dentures difficulty swallowing discharge dizziness
 ear drainage ear pain fainting frequent sore throats headaches
 hearing loss history of head injury hoarseness loss of sense of smell nasal congestion
 nosebleeds postnasal drip rhinorrhea (runny nose) sinus infections snoring
 sore throat tinnitus (ringing in ears) TMJ problems other:

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

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

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

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

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

- abdominal pain belching black - tarry stools constipation diarrhea
 difficulty swallowing heartburn hemorrhoids indigestion jaundice
 nausea rectal bleeding abnormal stool caliber abnormal stool color abnormal stool consistency
 vomiting vomiting blood other:

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control breast lumps/pain burning urination cramps frequent urination

- hormone therapy irregular menstruation pregnancy urine retention vaginal bleeding
 vaginal discharge other:

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

- burning urination erectile dysfunction frequent urination hesitancy/dribbling prostate problems
 urine retention other:

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

- cold intolerance diabetes excessive appetite excessive hunger excessive thirst
 abnormal frequency of urination goiter hair loss heat intolerance unusual hair growth
 voice changes other:

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

- changes in nail texture changes in skin color hair growth hair loss hives
 history of skin disorders itching paresthesias rash skin lesions / ulcers
 varicosities other:

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness facial weakness headache limb weakness loss of consciousness
 loss of memory numbness seizures sleep disturbance slurred speech
 stress strokes tremor unsteadiness of gait loss of balance
 other:

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

- anhedonia anxiety loss or change in appetite behavioral change bi-polar disorder
 confusion convulsions depression insomnia memory loss
 mood change other:

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

- anaphalaxis food intolerance itching nasal congestion rash
 sneezing other:

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

- anemia bleeding blood clotting blood transfusion bruising easily
 fatigue lymph node swelling other:

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

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____
 Were you satisfied with your care? Yes No. Why? _____

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

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

Females ONLY: Mark all that apply below.

- I AM: currently pregnant NOT pregnant unsure

Past Pregnancy History: C-section vaginal delivery miscarriage

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury broken bones fall (severe) fracture
 disability (ies) head injury loss of consciousness joint injury
 laceration (severe) motor vehicle accident soft tissue injury other:

Social History: Mark all that apply below.

Tobacco: Do not use Tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
 Smoke: # ___ per Day Week Month; Chew: # ___ cans per Day Week Year

Employment Information

Business Name: _____ Occupation/Job Title: _____
Business Address: _____ Name of Supervisor: _____
Business Phone: (_____) _____ - _____ Type of Work: _____

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 Social Security #: _____ - _____ - _____ 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 understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

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

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____