CONFIDENTIAL PATIENT HEALTH RECORD

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Dear Patient: This information is considered confidential. We need this information because your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Home Phone ( ) _____
Last First Middle Initial

Address_____ City_____ State_____ Zip_____

Email_____

Sex_____ Age_____ Birth Date_____ Height_____ Weight_____

Marital Status_____ How many children_____ Ages_____

Occupation_____ Employer_____

Address_____ Office Phone ( ) _____

Name of Spouse_____ Occupation_____

Employer_____ Office Phone ( ) _____

Patient's Nearest Relative_____ Phone ( ) _____

Referred By_____ Insurance Company_____

Present Family Doctor_____ Address_____

MAJOR HEALTH COMPLAINT_____

_____

When Did It Begin?_____ What Caused It?_____

Is the pain constant or intermittent and/or: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Tingling ☐ Burning ☐ Numbing

Does the pain move: ☐ Up ☐ Down ☐ Outward Is it getting worse ☐ Yes ☐ No Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Explain:_____

_____

Have you ever had this pain before? ☐ Yes ☐ No When and what did you do_____

Was it effective? ☐ Yes ☐ No

Is this the result of any type of accident?_____ ☐ Auto ☐ Work ☐ Home ☐ Other Accident Date_____

Are you now disabled from work?_____ How long_____

Doctors consulted for this condition:

Date_____ Name_____ Specialty_____ Address_____

Diagnosis/Treatment_____ Results_____

Date_____ Name_____ Specialty_____ Address_____

Diagnosis/Treatment_____ Results_____

Which of these factors affect your trouble (please check):

	No Effect	Better	Worse		No Effect	Better	Worse
Movement	☐	☐	☐	Reaching up/down	☐	☐	☐
Sitting	☐	☐	☐	During the night	☐	☐	☐
Standing	☐	☐	☐	First thing in the a.m.	☐	☐	☐
Walking	☐	☐	☐	Time of greatest activity	☐	☐	☐
Lying down	☐	☐	☐	While resting	☐	☐	☐
Bending	☐	☐	☐	Before meals	☐	☐	☐
Exercising	☐	☐	☐	During meals	☐	☐	☐
Twisting	☐	☐	☐	After meals	☐	☐	☐
Driving	☐	☐	☐	2-4 hours after meals	☐	☐	☐
Coughing	☐	☐	☐	Near end of day	☐	☐	☐
Sneezing	☐	☐	☐				

With 10 being highest, please rate how stressful your life has been overall?_____

Have you sustained any great traumas in your life prior to now? ☐ Yes ☐ No

If yes, please list_____

_____

_____

What surgery have you had?

Type_____ When_____ Doctor_____

Type_____ When_____ Doctor_____

Type_____ When_____ Doctor_____

Any surgical implants? ☐ Yes ☐ No Explain_____

Serious accidents and falls

What_____ When_____

What_____ When_____

Fractures

What_____ When_____

What_____ When_____

Conditions previously treated

What_____ When_____

What_____ When_____

Medications/supplements you take

What_____ Frequency_____ Doctor_____

What_____ Frequency_____ Doctor_____

What_____ Frequency_____ Doctor_____

Family Health Information	Age	Deceased	Diabetes	Heart	Kidney	Cancer	Musculo-Skeletal (Back, Neck, etc.)
Father							
Mother							
Brothers							
Sisters							

Vaccinations: ☐ Yes ☐ No Any Reaction?_____

Present or past history of bedwetting?_____ Handedness ☐ Right ☐ Left ☐ Both

Have you now or ever had the following deficiencies? ☐ Hearing ☐ Reading ☐ Hesitant Speech ☐ Stuttering ☐ Visual ☐ Memory

☐ Comprehension ☐ Attention Span ☐ Depth/Time Perception ☐ Phobias ☐ Writing Skills

Special Education: ☐ Yes ☐ No Tutors: ☐ Yes ☐ No Present Education Level_____

Date of last Physical Examination_____ By Doctor_____

Results_____

Chest X-rays_____ Spinal X-rays_____ Dental X-rays_____ Other X-rays_____

Blood Test_____ Urine Test_____ Other Tests_____

Allergies: Are you allergic to…	No	Yes		No	Yes	
Penicillin	☐	☐	Sulfa Drugs	☐	☐	Aspirin
Codeine	☐	☐	Morphine	☐	☐	Antitoxin
Other Antibiotics	☐	☐	Tetanus	☐	☐	Explain_____
Serums	☐	☐	Any Other Drugs	☐	☐	Explain_____
Adhesive Tape	☐	☐	Any Foods	☐	☐	Explain_____
Nail Polish	☐	☐	Other Cosmetics	☐	☐	

Health Habits: Do you…	No	Yes		No	Yes
Exercise Adequately	☐	☐	Awaken Rested	☐	☐
How?_____			Sleep Well	☐	☐
Average 8 Hours Sleep (Per Night)	☐	☐	Have Regular Bowel Movements	☐	☐
Sex – Entirely Satisfactory	☐	☐	Like Your Work (Hrs/Day) ☐ Indoors ☐ Outdoors	☐	☐
Watch TV (Hrs/Day)	☐	☐	Read (Hrs/Day)	☐	☐
Have a Vacation (Weeks/Year)	☐	☐	Have You Ever Been Treated for Alcoholism	☐	☐
Have You Ever Been Treated for Drug Abuse	☐	☐			

Please Check All of the Following Which You Are Taking:

☐ Antacids	☐ Antibiotics	☐ Antidepressants
☐ Antidiabetic/Insulin	☐ Aspirin/Tylenol	☐ Chemotherapy
☐ Cortisone/Anti-inflammatories	☐ Heart Medications	☐ High Blood Pressure Medications
☐ Laxatives	☐ Lithium	☐ Oral Contraceptives
☐ Radiation	☐ Recreational Drugs	☐ Relaxants/Sleeping Pills
☐ Thyroid Medications	☐ Ulcer Medications	☐ Other:_____

Dental Work and Doctor's Name for TMJ. Bridges, Dentures, Braces:_____

Rate your level of stress from 1 to 10(10 being the highest)_____ Do you have sufficient energy for your normal activities?_____

When was the last time you really felt good?_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment, however, these questions must be answered carfully, as these problems can affect your overall course of your care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Malaria
- ☐ Goiter
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ _____

CIRCLE CURRENT CONDITIONS AND CHECK (V) FORMER CONDITIONS

GENERAL SYMPTOMS

- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Loss of Weight
- ☐ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees or feet
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion

EYES, EARS, NOSE & THROAT

- ☐ Failing Vision
- ☐ Near Sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Hay fever
- ☐ Allergies
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

RESPIRATORY

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Whooping cough
- ☐ Influenza
- ☐ Pleurisy
- ☐ Asthma

CARDIO-VASCULAR

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over the heart
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart attack
- ☐ Varicose veins

MUSCLE AND JOINT

- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Pain between shoulders
- ☐ Hernia
- ☐ Spinal curvature (Scoliosis)
- ☐ Faulty posture
- ☐ Arthritis
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

SKIN

- ☐ Skin eruption itching
- ☐ Itching
- ☐ Bruises easily
- ☐ Dryness
- ☐ Boils
- ☐ Rashes
- ☐ Sensitive skin
- ☐ Hives or allergy
- ☐ Eczema

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over the stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Bloody stool
- ☐ Colon trouble
- ☐ Hemorrhoids (Piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble
- ☐ Antibiotic therapy
- ☐ Appendicitis
- ☐ Ulcers
- ☐ Goiter
- ☐ Gout

GENITOURINARY

- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate trouble
- ☐ Bladder trouble
- ☐ Discolored urine

FEMALE

- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back ache
- ☐ Miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps in the breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding

When was your last period

_____

Are you pregnant:

- ☐ Yes
- ☐ No
- ☐ Not sure

OTHER

- ☐ Foot Orthotic/Supports
- ☐ Prosthesis
- ☐ Breast implants

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS

Diagnosis:

Patient accepted: ☐ Yes ☐ No

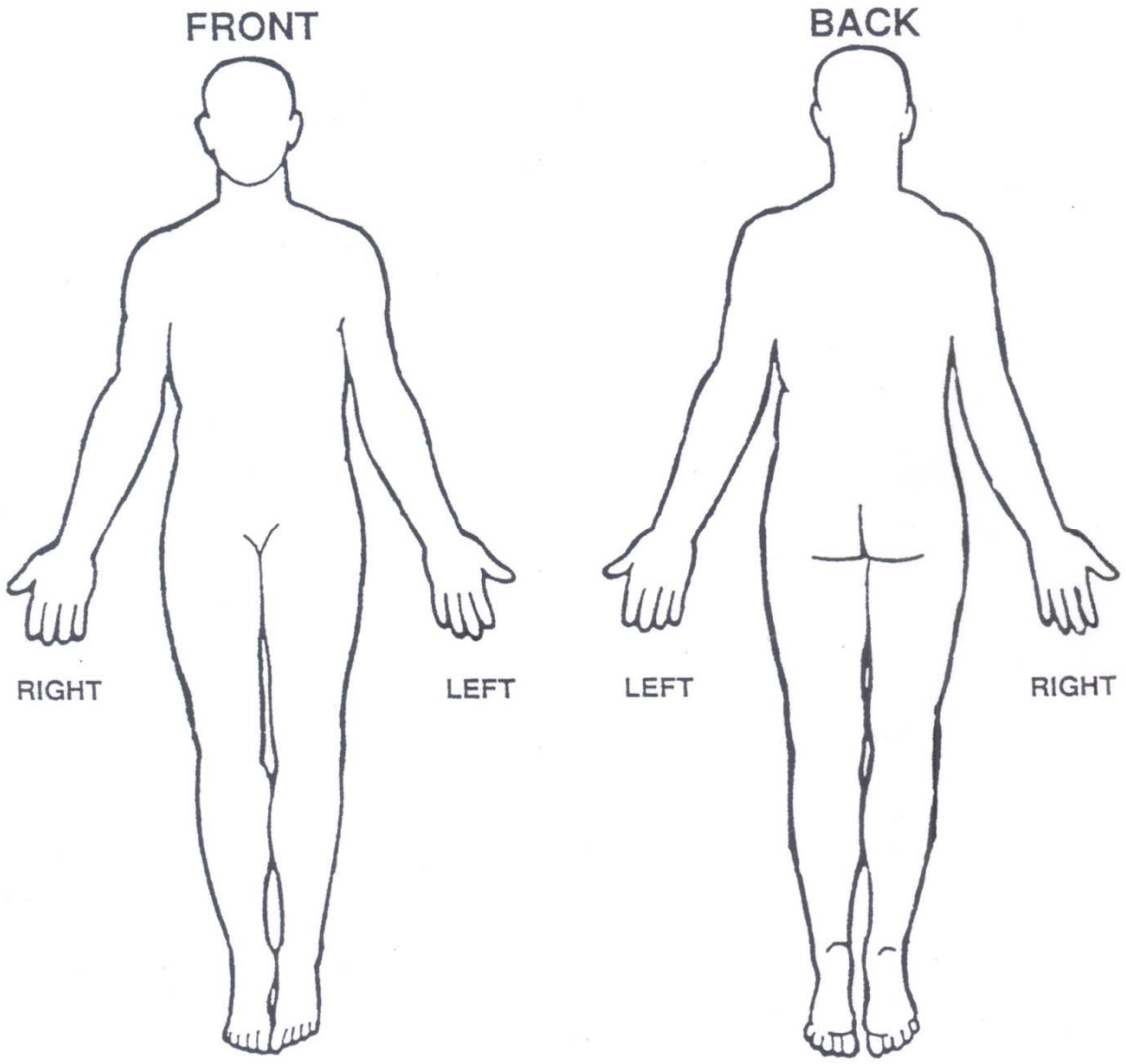
Doctor's Signature_____

PAIN DRAWING ASSESSMENT

Draw the location of your pain on the body outlines using the appropriate symbols. Include all affected areas. Just to complete the picture draw in your face. Make the severity of your pain at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS AND NEEDLES	STABBING
ZZZ	BBB	XXXX	= = =	////
ZZZ	BBB	XX	= = =	///

Percentage of pain in back_____ Percentage of pain in legs_____



NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN

In understand and agree that payment is due and payable at the time services are rendered. Furthermore, I understand that payment for any remedy that is shipped to me at my request is to be paid upon receipt. I also understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from my insurance carrier upon my request. I do understand and agree that the Doctor's Office will not and is under no obligation to fill out or file any insurance claims for me, nor are they to await payment for said claims. I clearly understand that any health or accident insurance policies or disputes are between an insurance carrier and myself and that I am responsible for the full balance incurred by me.

CANCELLATION POLICY: Appointments cancelled without 24 hours' notice are subject to a $75 cancellation fee.

Patient Signature_____ SS#_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____