# 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** ______

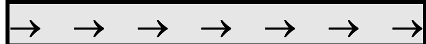
**Email Address:** _____________________________ **Spouse Name:** __________________________________

## *Current Health Condition*

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

_______________________________________________________

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



**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:** _____________________

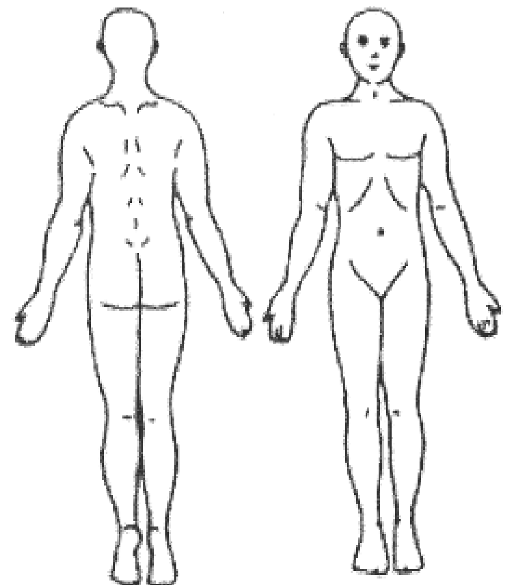
**Do you SUFFER with ANY OTHER Condition than which you are now consulting us?**

_____________________________________________________________

_____________________________________________________________

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

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



Patient Name: ____________________________________ Date:________________

**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 ☐ TMJ problems
☐ difficulty swallowing ☐ fainting ☐ hoarseness ☐ rhinorrhea (runny nose) ☐ tinnitus (ringing in ears)
☐ 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

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

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

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

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

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

☐ birth control ☐ cramps ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ vaginal discharge
☐ burning urination ☐ hormone therapy ☐ urine retention

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

☐ burning urination ☐ frequent urination ☐ prostate problems
☐ erectile dysfunction ☐ hesitancy/ dribbling ☐ urine retention

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

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

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

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

Patient Name: ___________________________________ Date:________________

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

**☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor**
**☐ facial weakness ☐ loss of consciouness ☐ seizures ☐ stress ☐ unsteadiness of gait/ Loss of balance**
**☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes**

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

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

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

**☐ anaphalaxis ☐ itching ☐ chronic nasal congestion ☐ sneezing**
**☐ food intolerance ☐ acute nasal congestion ☐ rash**

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

**☐ anemia ☐ blood clotting ☐ bruising easily ☐ lymph node swelling**
**☐ bleeding ☐ blood transfusion ☐ fatigue**

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## 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 ☐ chicken pox ☐ headaches ☐ scoliosis**
**☐ atopic dermatitis (eczema) ☐ crohn's/colitis ☐ hepatitis ☐ seizure disorder**
**☐ allergies/hayfever ☐ depression ☐ HIV ☐ sickle cell anemia**
**☐ anemia ☐ diabetes ☐ measles ☐ spina bifida**
**☐ asthma ☐ ear infections ☐ mumps ☐ other:**
**☐ bedwetting ☐ fetal drug exposure ☐ psoriasis**
**☐ cerebral palsy ☐ food allergies (list below) ☐ rash**

Patient Name: ___________________________________ Date:________________

*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 (discoid)
- ☐ 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.**

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

- ☐ angioplasty
- ☐ appendectomy
- ☐ caesarian section
- ☐ cardiac catheterization
- ☐ carpal tunnel repair
- ☐ coronary artery bypass
- ☐ cosmetic
- ☐ D & C
- ☐ dental surgery
- ☐ gall bladder
- ☐ hemorrhoidectomy
- ☐ hernia repair
- ☐ hysterectomy
- ☐ joint reconstruction
- ☐ joint replacement
- ☐ knee repair
- ☐ laminectomy
- ☐ mastectomy
- ☐ pacemaker insertion
- ☐ rotator cuff
- ☐ spinal fusion
- ☐ tonsilectomy
- ☐ other:

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

- ☐ 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:

*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:** _____________