

# 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.  Dr.  
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: \_\_\_\_\_ County: \_\_\_\_\_ -  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Email Address: \_\_\_\_\_  
Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

## Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

## Employment Information

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Job Description \_\_\_\_\_

## 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 Number \_\_\_\_\_

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

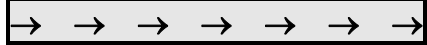
Date: \_\_\_\_\_

**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

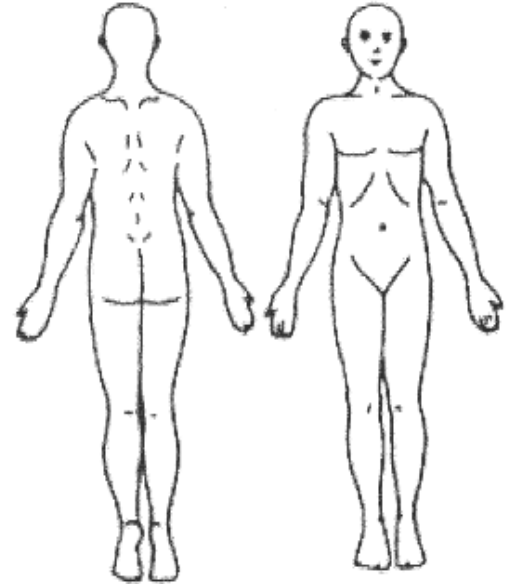
Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am /pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

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 do NOT have any of the symptoms or problems listed below.

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

**Eyes/Vision:**  I do NOT have 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 do NOT have 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

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

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

**Respiration:**  I do NOT have any of the symptoms or problems listed below.

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

**Cardiovascular:**  I do NOT have any of the symptoms or problems listed below.

- angina (chest pain or discomfort)       high blood pressure       shortness of breath with exertion or exercise  
 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)

**Gastrointestinal:**  I do NOT have 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 do NOT have 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 do NOT have any of the symptoms or problems listed below.

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

**Endocrine:**  I do NOT have 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 do NOT have 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

**Nervous System:**  I do NOT have any of the symptoms or problems listed below.

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

**Psychologic:**  I do NOT have 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 do NOT have any of the symptoms or problems listed below.

- anaphalaxis       itching       chronic nasal congestion       sneezing  
 food intolerance       acute nasal congestion       rash

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

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

**Hematologic:**  I do NOT have any of the symptoms or problems listed below.

- anemia                       blood clotting                       bruising easily                       lymph node swelling
- bleeding                       blood transfusion

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

**Previous Care for Same Condition:**  I have not 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. Check 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

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

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

**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:**

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

**Social History**

- Alcohol:  Never  Social Consumption only  Beer  Liquor  Wine ; \_\_\_\_\_ oz \_\_\_\_\_ glasses;  Day  Week  Month
- Diet (please mark all that apply):  High Fat  High Fiber  High Protein  High Salt  
 Low Calorie  Low Carb  Low Fiber  Low Salt  Low Sugar
- Education (please mark the highest level completed):  Preschool  Elementary  Middle  Junior High  Votech  
 In High School  Did Not Finish High School  High School Diploma  Post High School Classes  Assoc/Technical Degree  
 In College  College Degree  In Graduate School  Graduate Degree  Doctorate  Other: \_\_\_\_\_
- Drugs:  Deny any illegal drug use  Deny use of IV drugs  Have not used drugs since \_\_\_\_\_  Have used drugs for \_\_\_\_\_
- Tobacco:  Deny Tobacco Use  Do not smoke cigars, cigarettes or pipe  Live with a smoker  Quit smoking  
 Smoke; # \_\_\_\_\_ per  Day  Week  Month  Chew; # \_\_\_\_\_ cans per  Day  Week  Year