

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

Last: _____ First: _____ Middle: _____
Birth Date: ___ / ___ / ___ Age: _____ Sex: Male / Female
Marital Status: Single Married Widowed Divorced Separated
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ - _____ ext _____ Work Phone: (_____) _____ - _____ ext _____
Cell Phone: (_____) _____ - _____ ext _____ Fax #: (_____) _____ - _____ ext _____
Email Address: _____

Emergency Contact

Last: _____ First: _____ Middle: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Relationship: Spouse Relative Friend Other _____
Home Phone: (_____) _____ - _____ ext _____ Cell Phone: (_____) _____ - _____ ext _____
Work Phone: (_____) _____ - _____ ext _____ Fax #: (_____) _____ - _____ ext _____

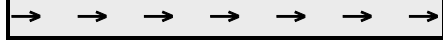
Employment Information

Business Name: _____
Address: _____ Suite # _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Occupation/Job Title: _____

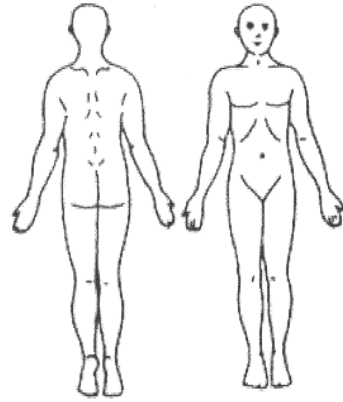
Current Health Condition

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



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.

- change in vision eye pain wear glasses/contacts

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

- dizziness ear pain history of head injury fainting TMJ problems
 difficulty swallowing tinnitus (ringing in ears)

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

- asthma shortness of breath

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

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

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

- abdominal pain difficulty swallowing nausea constipation

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

- birth control pregnancy hormone therapy

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

- erectile dysfunction prostate problems

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

- diabetes

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

- changes in skin color history of skin disorders skin lesions / ulcers

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

- dizziness limb weakness numbness strokes unsteadiness of gait/loss of balance
 facial weakness loss of consciousness seizures loss of memory headache

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

- anxiety behavioral change insomnia depression

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

- drug/ medication allergy:

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

- anemia blood clotting bruising easily lymph node swelling
 blood transfusion

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: _____ Were you satisfied with the results of your treatment? 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: _____

Were you satisfied with your care? Yes No. Why? _____

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

For how long? _____ Were they prescribed by a doctor? Yes or No.

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?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> anemia | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> lung disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lupus erythema (discoid) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> vertigo | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> hepatitis | <input type="checkbox"/> other: | |

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

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> laminectomy | <input type="checkbox"/> rotator cuff | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> joint replacement | <input type="checkbox"/> knee repair | <input type="checkbox"/> other: |

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

- back injury
- broken bones
- fall (severe)
- fracture
- head injury (loss of consciousness)
- head injury (no loss of consciousness)
- industrial accident
- joint injury
- motor vehicle accident
- soft tissue injury (mild/mod/severe)
- laceration (severe)
- other:

Family History: List any specific conditions past or present after 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 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: _____

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ **Date:** _____

Chief Complaint: _____

Condition: New or Old Other: _____

Mechanism of Onset:

- Auto: Driver/Passenger Pedestrian (refer to completed auto accident history form)
- Work Related: Fall Falling Object Lifting Repetitive Motion Other: _____
- No Injury

Description of Onset of Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness

Location: Left / Right / Bilateral _____

- Quality:** Burning Diffuse Dull/Aching Localized Radiating Sharp
- Shooting Stabbing Throbbing Tightness Tingling
- Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: _____ Worsened: _____

Timing: Worse: Morning Afternoon Night with Activity; Constant Intermittent

Context: Better with: _____ Worse with: _____

- Assoc Signs and Symptoms:** Depression Dizziness Localized Tingling Nausea
- Ringing in Ears Sleep Disturbance Stiffness

Headaches: Location: _____

- Quality: Dull Sharp Throbbing Stabbing Aura No Aura
- Types: Migraine Tension

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

- aches burning cold limb(s) difficulty walking dizziness
- swelling muscle weakness tingling numbness joint stiffness
- muscle spasm pins & needles

Modifying Factors:

- Symptoms Better With: nothing helps activity bending applying cold rest
- applying heat massage movement OTC meds Rx meds walking
- stretching sitting standing twisting

Employment:

Occupation/Job Title: _____

Work Activity Postures: _____

- bending
- reaching
- climbing
- sitting
- kneeling
- standing
- pulling
- twisting
- pushing
- walking

Repetitive Activities:

- assembly/fine manipulation
- hand tool use
- computer use/typing
- operation of machinery controls
- grasping
- phone use

Condition's Effect On Job Performance:

- Mild Painful (Can do)
- Mod Painful (limited ability)
- Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Mod Sev
- Change Posn--Sit-Stand: No Effect Mild Mod Sev
- Climb Stairs: No Effect Mild Mod Sev
- Driving: No Effect Mild Mod Sev
- Extended Computer Use: No Effect Mild Mod Sev
- Household Chores: No Effect Mild Mod Sev
- Lifting: No Effect Mild Mod Sev
- Sleep: No Effect Mild Mod Sev
- Static Sitting: No Effect Mild Mod Sev
- Static Standing: No Effect Mild Mod Sev
- Walking: No Effect Mild Mod Sev
- Yard Work: No Effect Mild Mod Sev

Recreational Activity: Effects of Current Condition on Performance

- _____ No Effect Mild Mod Sev
- _____ No Effect Mild Mod Sev