Confidential Patient Health Record

Today's Date: ___/___/___

How did you hear about us? (Please Mark all that apply) ☐ Family ☐ Friend ☐ Co-Worker (Please list Name) _____
☐ SBC Ameritech ☐ Yellow Book ☐ Verizon ☐ Yellow pages (unknown) ☐ Close to home/work ☐ Drove by ☐ Insurance Plan
☐ Newspaper ☐ Radio ☐ Movie Theater ☐ Web Page ☐ Screening ☐ Lecture ☐ Dr. _____

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?): _____

_____

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

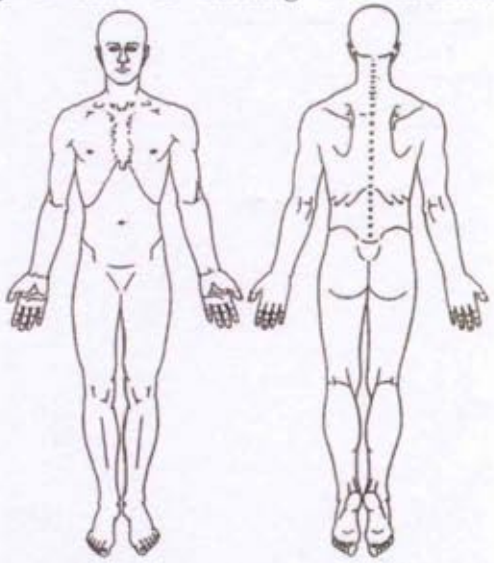
Condition/Pain STARTED on what Date: _____

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No

If yes, Who? (Name) _____

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

Key: A=Ache B=Burning N = Numbness



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 (waking at night w/ shortness of breath) ☐ shortness of breath with exertion or exercise ☐ swelling of legs
☐ 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: # ____ packs per ☐ Day ☐ Week ☐ Month; ☐ Chew: #_____cans per ☐ Day ☐ Week ☐ Year

☐ Pop/Soda: #_____cans per ☐ Day ☐ Week; ☐ Coffee: #_____cups per ☐ Day ☐ Week;

How many glasses of water a day do you drink _____

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 #: _____Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

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: _____