

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 satisfactorily, 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.

Date: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching up/down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	First thing in the a.m.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Time of greatest activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	While resting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Before meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	After meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-4 hours after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near end of day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	<input type="checkbox"/>	Antitoxin
Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Serums	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>	Any Foods	<input type="checkbox"/>	<input type="checkbox"/>	Explain _____
Nail Polish	<input type="checkbox"/>	<input type="checkbox"/>	Other Cosmetics	<input type="checkbox"/>	<input type="checkbox"/>	

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

Do you smoke or have you ever smoked

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 carefully, as these problems can affect the overall course of your care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Malaria | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Goiter | <input type="checkbox"/> _____ |

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

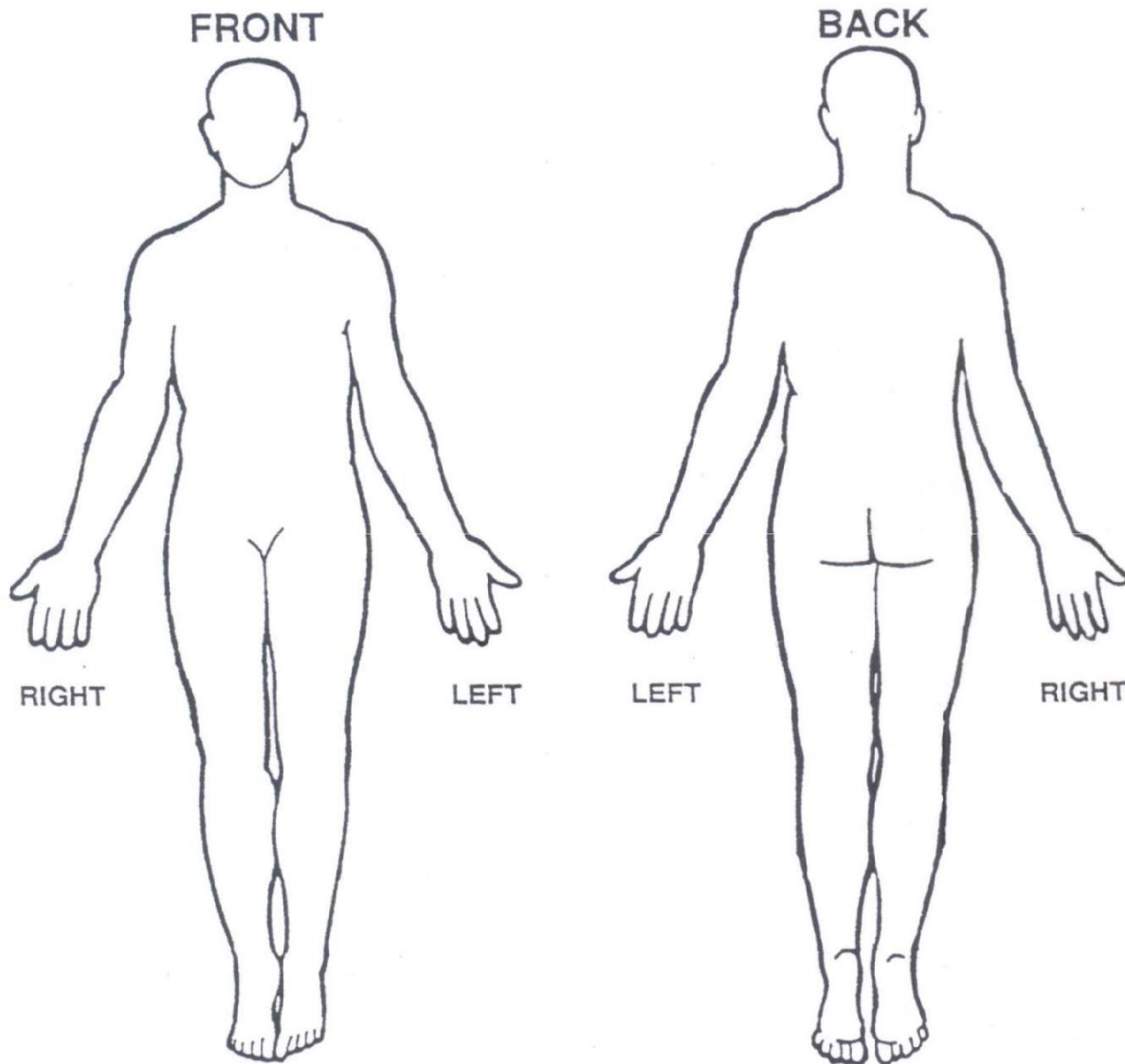
Doctor's Signature _____

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

I 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 me and my insurance carrier and that I am responsible for the full balance incurred by me. I also understand and agree to the following **CANCELLATION POLICY: Appointments may be cancelled up to 24 hours before the appointed time. Those cancelled fewer than 24 hours in advance are charged in full and I understand that I am responsible for that charge.**

Patient Signature _____ SS# _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____