

Dear patient: This information is considered confidential. We need this information because your answers will help us to determine if chiropractic 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.

**CONFIDENTIAL PATIENT HEALTH RECORD**

Date \_\_\_\_\_ Case # \_\_\_\_\_

Name \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home telephone ( ) \_\_\_\_\_ Social security # \_\_\_\_\_

Birth date \_\_\_\_\_  Married  Single  Widowed  Divorced Sex \_\_\_\_\_

\_\_\_\_\_  \_\_\_\_\_

**Employer** \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_

List name & complete mailing address of insurance company \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance telephone # \_\_\_\_\_

Name of insured person \_\_\_\_\_

Address of insured person \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship of insured to patient  Self  Spouse  Child  Other \_\_\_\_\_

Insurance group name and # \_\_\_\_\_

Insurance policy \_\_\_\_\_

Claim # if accident \_\_\_\_\_ Date of accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of **most recent** onset of symptoms \_\_\_\_/\_\_\_\_/\_\_\_\_

Was this an accident? \_\_\_\_\_  Due to employment  Due to auto  Due to other

Age \_\_\_\_ No. of children \_\_\_\_\_

Ages \_\_\_\_\_

Spouse \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Office phone ( ) \_\_\_\_\_

Present family Dr. \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**COMPLAINT:** \_\_\_\_\_

\_\_\_\_\_  L  R  RD

Date onset: \_\_\_\_/\_\_\_\_/\_\_\_\_ Location of pain: \_\_\_\_\_

Activity during injury: \_\_\_\_\_

Pain is:  Sharp  Nagging  Burning  Dull  Shocklike  Numb  Constant  Comes and goes

Pain:  Local  Travels to other areas: \_\_\_\_\_

Ever had before?  Yes  No If so, when? \_\_\_\_\_

Worst when:  Lying  Sitting  Driving  Standing  Working  Household  Lifting  Sleeping  Stressed  Exercise

Better when:  Ice  Heat  Sleep  Exercise  Chiropractic Care  Medication (type): \_\_\_\_\_

Previous treatment: \_\_\_\_\_  None

M.D. (name) \_\_\_\_\_ Specialty: \_\_\_\_\_

X-rays or other tests: \_\_\_\_\_

Treatment: \_\_\_\_\_

Chiropractor (name) \_\_\_\_\_ Specialty: \_\_\_\_\_

X-rays or other tests: \_\_\_\_\_

Treatment: \_\_\_\_\_

Other (name) \_\_\_\_\_ Specialty: \_\_\_\_\_

X-rays or other tests: \_\_\_\_\_

Treatment: \_\_\_\_\_

Have you missed any time from work due to this problem? \_\_\_\_\_ Dates: \_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_

**OTHER COMPLAINTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What surgery have you had?**

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Remarks \_\_\_\_\_

**List previous accidents and falls:**

What \_\_\_\_\_ When \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_

Remarks \_\_\_\_\_

**List fractures and dislocations:**

What \_\_\_\_\_ When \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_

Remarks \_\_\_\_\_

**List previous or unrelated medical problems:**

What \_\_\_\_\_ When \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_  
What \_\_\_\_\_ When \_\_\_\_\_

Remarks \_\_\_\_\_

**List medications and/or vitamins you take:**

What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_  
What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_  
What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_  
What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_  
What \_\_\_\_\_ Frequency \_\_\_\_\_ Doctor \_\_\_\_\_

Remarks \_\_\_\_\_

**Family Health Information:**

Father: Age \_\_\_\_\_  Deceased  Back/neck pain  Arthritis  Heart/blood press.  Cancer \_\_\_\_\_  Diabetes  Other \_\_\_\_\_

Mother: Age \_\_\_\_\_  Deceased  Back/neck pain  Arthritis  Heart/blood press.  Cancer \_\_\_\_\_  Diabetes  Other \_\_\_\_\_

Brothers: Age \_\_\_\_\_  Deceased  Back/neck pain  Arthritis  Heart/blood press.  Cancer \_\_\_\_\_  Diabetes  Other \_\_\_\_\_

Sisters: Age \_\_\_\_\_  Deceased  Back/neck pain  Arthritis  Heart/blood press.  Cancer \_\_\_\_\_  Diabetes  Other \_\_\_\_\_

Dates of last:

Physical examination \_\_\_\_\_ Why was it done? \_\_\_\_\_

Dr. \_\_\_\_\_ Results: \_\_\_\_\_

Chest X-rays \_\_\_\_\_ Spinal X-rays \_\_\_\_\_ Dental X-rays \_\_\_\_\_ Other X-rays \_\_\_\_\_

Blood test \_\_\_\_\_ Urine test \_\_\_\_\_ Other tests \_\_\_\_\_

Health Habits: How much per day or week?

Tea, coffee \_\_\_\_\_ Liquor \_\_\_\_\_ Tobacco \_\_\_\_\_ Hours sleep \_\_\_\_\_

Exercise \_\_\_\_\_ Type \_\_\_\_\_ Special diets: \_\_\_\_\_

Do you wear: Heel lifts \_\_\_\_\_ Sole lifts \_\_\_\_\_ Arch supports \_\_\_\_\_ Other \_\_\_\_\_

**Check any of the following diseases you have or have had:**

- |   |   |                                     |  |   |  |
|---|---|-------------------------------------|--|---|--|
| <input type="checkbox"/> AIDS             | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Malaria            | <input type="checkbox"/> Pleurisy        |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Typhoid Fever    | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Gout          | <input type="checkbox"/> Measles            | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental disorder    | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Eczema     | <input type="checkbox"/> Herpes        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Whooping cough   | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Scarlet fever   |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Chorea           | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Mump               | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Cancer           |   |                                     |  |   |  |

**Circle (O) current conditions      Check (✓) 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 and 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
- Asthma
- Dental decay
- Gum troubles
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands

**Skin**

- Skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Rashes
- Sensitive skin
- Hives or allergy

**Respiratory**

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing
- Wheezing

**Cardio-vascular**

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke
- Varicose veins

**Muscle and joint**

- Stiff neck
- Back ache
- Swollen joints
- Painful tail bone
- Foot trouble
- Pain between shoulders
- Hernia
- Spinal curvature
- Faulty posture
- Arthritis
- Stiff joints
- Painful joints
- Sore muscles
- Weak muscles
- Walking problems
- Sciatica

**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

**Gastrointestinal**

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Belching or gas
- Nausea
- Vomiting
- Vomiting of blood
- Pain over 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

**Female**

- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or back ache
- Previous miscarriage
- Vaginal discharge
- Vaginal pain
- Congested breast
- Breast pain
- Lumps in breast
- Menopausal symptoms
- Abnormal bleeding

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office 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 Doctor's Office will be credited to my account on 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Guardian or spouse's signature authorizing care \_\_\_\_\_ Date \_\_\_\_\_

Please return this completed form to the receptionist.