

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 _____

Email: _____ _____

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 it 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: _____

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 my 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.