Confidential Patient Health Record

(Please Print)

Full Legal Name: _____ Date of Birth: _____

Street Address / P.O. Box _____ Home Phone: _____

City / State / Zip: _____ Mobile Phone: _____

Social Security Number: _____ Work Phone: _____

Gender: ☐Male ☐Female ☐Other: _____ Ethnicity: ☐Hispanic ☐Non-Hispanic

Race (select one): ☐ White/Caucasian ☐American Indian ☐Asian ☐Black/African American ☐Other: _____

Preferred Language: ☐English ☐French ☐Spanish ☐Russian ☐Polish ☐Chinese ☐Other: _____

Your Employer: _____ Job Title: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Email: _____

Spouse's Name: _____ Spouse's Date of Birth: _____ Spouse's Employer: _____

Names / Ages of Children: _____

Who Should We Notify in an Emergency? _____ Relationship: _____ Phone #: _____

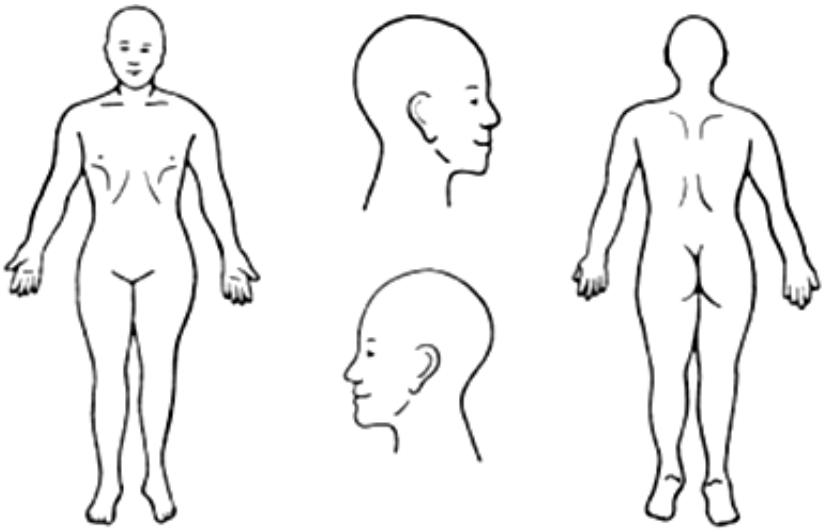
Who is Your Medical Doctor? _____ Facility / City: _____

Did Any of The Following Refer You to Us? ☐My M.D. ☐Another Person: _____ Other: _____

History of Present Illness / Injury

Fill out this section by marking the area with the described sensation using the appropriate symbols from the left.

X X X Burning Pain
((((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain



Please Complete:

_____ Constant
_____ Come & Go
_____
_____ Getting Better
_____ Getting Worse
_____ Staying Same
_____

Better:		Worse:
_____	AM	_____
_____	Mid-Day	_____
_____	PM	_____

Rate Your Discomfort/Symptom(s):

Enter the number below that corresponds with your degree of discomfort. **"0"** is NO pain/symptom(s), **"100"** is intolerable Pain/Symptoms.

Neck (0= No Pain):	**Mid Back (0= No Pain):**	**Low Back (0= No Pain):**	_____:	_____:
Best: _____/100	Best: _____/100	Best: _____/100	Best: _____/100	Best: _____/100
Worst: _____/100	Worst: _____/100	Worst: _____/100	Worst: _____/100	Worst: _____/100
Now: _____/100	Now: _____/100	Now: _____/100	Now: _____/100	Now: _____/100
Usual: _____/100	Usual: _____/100	Usual: _____/100	Usual: _____/100	Usual: _____/100

How Did It Occur? ☐ Work – Related Injury ☐ Auto Accident ☐ Other: _____

When Did They Begin? _____ Have You Missed Work? ☐**Yes** ☐**No** How Much? _____

Indicate Your Ability to Perform the Following Activities. Please Use the Following Codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

1. _____ Lying on Back	5. _____ Sexual Activity	9. _____ Bending Forward/Lifting
2. _____ Lying on Sides	6. _____ Getting In / Out of Car	10. _____ Prolonged Standing
3. _____ Lying on Stomach	7. _____ Pushing / Pulling	11. _____ Using a Computer
4. _____ Turning Over in Bed	8. _____ Up/Down Stairs	12. _____ Sitting/Driving/Riding

16. _____ Dressing Self	
17. _____ Walking	
18. _____ Cough / Sneeze/ Grunt	
19. _____	

What Makes the Condition Better? (Ice, Adjustments, Ibuprofen, Stretching, etc.)

Head / Neck _____ Shoulder, Arm, Hand _____
Mid Back _____ Hip, Leg, Foot _____
Low Back _____ Other _____

YES NO

☐ ☐ Does the Discomfort Interfere with your Sleep?
- ♦How Many Times Does It Wake You Up? _____

☐ ☐ Do You Sleep with a Pillow? How Many? _____
- ♦Where? _____
- ♦What Positions Do You Sleep In? _____
- ♦How Old is Your Mattress? _____
- ♦How Much Sleep Do You Average/Night? _____

☐ ☐ Does Using a Heating Pad Help/Hurt? How? _____

☐ ☐ Does Using an Ice Pack Help/Hurt? How? _____

☐ ☐ Do You Wear a Heel Lift? Which Side? (**Left** or **Right**)

☐ ☐ Do You Wear Foot Orthotics?

Females: Are You Pregnant? ☐ yes ☐ no

Due Date: _____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

Males: Date of Last Prostate & Testicular Exam: _____

Neck & Headache Questions

YES NO

☐ ☐ Difficulty Turning Head? ☐ Left ☐ Right
☐ ☐ Do You Hear Grating / Crackling Sounds?
☐ ☐ Do You Try to "Crack" Your Own Neck?
☐ ☐ Do You Get Pain or Cracking in Jaw?
☐ ☐ Do You have Nausea, Vomiting, Visual Disturbances, Altered Hearing, Ringing in Ears, or Loss of Balance?
☐ ☐ Do You Get Pain or Pressure Behind the Eye(s)? R or L
☐ ☐ Do You Have Abnormal Blood Pressure?

♦Location of Headaches: _____
♦Frequency of Headaches: _____ per _____
♦Date of Last Eye Exam: _____. Any Rx Changes? Y or N

Low Back Pain Questions

YES NO

☐ ☐ Does Pain Radiate to the Abdomen and/or Groin?
☐ ☐ Any Impairment of Bowel or Bladder Function?
- ♦Explain? _____

☐ ☐ Do You Try to "Crack" Your Own Back?

Past Medical History

How Many Times Have You Had the Condition That You Are Seeing Us for Today?

☐ Never ☐ 1-3 Times ☐ 4 or More Times

Please List Any Other Health Conditions you Have: (check all that apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer
☐ Thyroid ☐ Infertility Issues ☐ Others: _____

Have You Ever Seen a Chiropractor Before? ☐**yes** ☐**no**

♦ When Was the Last Time You Were Seen? _____ Which Dr./Facility? _____
♦ For What Problem(s)? _____ Were You Helped? _____
♦ How Often Were You Being Seen? _____ Why Did You Leave? _____

List Any Other Chiropractors You've Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

List Any MD's, Physical Therapists, or Other Health Professionals You've Seen for This Condition Before: (Use More Paper as needed.)

Date	Name	Facility	Condition(s)	Treatment Type(s)

List Any Other Self Care Remedies You've Attempted to Alleviate Your Condition? (e.g. massage, vibration gun, topical ointments or Home Medical Equipment such as braces/supports, cervical pillow, low back support belt, stretching, exercising, etc.)

_____

Describe Any Major Illnesses, Injuries, Falls, Hospitalizations, Auto Accidents, and/or Surgeries: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

LIST ANY VITAMINS OR SUPPLEMENTS YOU TAKE FOR SPECIFIC CONDITIONS OR FOR GENERAL WELLNESS:

NAME OF VITAMIN/SUPPLEMENT	DOSAGE?	FOR WHAT CONDITION(S)	WHERE DO YOU BUY IT?

CURRENT PRESCRIPTION MEDICATIONS:

NAME OF MEDICATION	DOSAGE?	FOR WHAT CONDITION(S)	FREQUENCY (# PER DAY/WEEK)

LIST ANY DRUG ALLERGIES:

☐NONE ☐LIST: _____

SMOKING STATUS:

☐HEAVY SMOKER (1/2 PK/DAY OR MORE) ☐LIGHT SMOKER (LESS THAN ½ PK/DAY) ☐SMOKING STATUS UNKNOWN

☐FORMER SMOKER (_____ PKS/DAY OR _____ CIGS/DAY; SMOKED FROM AGE: _____ TO AGE: _____)

☐NEVER SMOKED

FAMILY HEALTH HISTORY

MOTHER: ALIVE? ☐YES ☐NO HEALTH CONDITIONS: _____

FATHER: ALIVE? ☐YES ☐NO HEALTH CONDITIONS: _____

BROTHERS/SISTERS: HOW MANY OF EACH? _____ HEALTH CONDITIONS: _____

CHILDREN: HOW MANY? _____ HEALTH CONDITIONS: _____

SOCIAL HEALTH HISTORY

STUDENT: ☐N/A ☐PART-TIME ☐FULL-TIME ☐SCHOOL: _____

EMPLOYMENT STATUS: ☐UNEMPLOYED ☐ON DISABILITY ☐RETIRED ☐PART-TIME ☐FULL-TIME ☐OTHER: _____

OCCUPATION: _____ HRS PER WEEK: _____ YRS ON JOB: _____ YRS WITH EMPLOYER: _____

RECREATIONAL ACTIVITIES / HOBBIES: _____

YES NO

☐ ☐ DO YOU EXERCISE? HOW OFTEN? _____ IN WHAT WAY? _____

HOW MUCH WATER DO YOU DRINK? _____

☐ ☐ DO YOU CONSUME CAFFEINE? HOW MUCH & HOW OFTEN? _____

☐ ☐ DO YOU CONSUME ALCOHOL? HOW MUCH & HOW OFTEN? _____

☐ ☐ DO YOU HAVE HIGH STRESS LEVELS AT HOME? IF SO, WHY? _____

☐ ☐ DO YOU HAVE HIGH STRESS LEVELS AT WORK/SCHOOL? IF SO, WHY?

YOUR QUALITY OF LIFE

WHAT IS/ARE THE MAJOR STRESSES IN YOUR LIFE CURRENTLY: (CHECK ALL THAT APPLY)

☐ YOUR HEALTH ☐ RELATIONSHIP(S) ☐ WORK/SCHOOL ☐ YOUR FINANCES ☐ OTHER: _____

WHAT WOULD BE THE MOST SIGNIFICANT THING(S) YOU COULD DO TO IMPROVE YOUR HEALTH: (CHECK ALL THAT APPLY)

☐ BEING HERE! ☐ DIET/EXERCISE ☐ BETTER SLEEP ☐ I DON'T KNOW ☐ OTHER: _____

System Review Questions

Have You Had Any Problems with the Following Areas Now or in the Past? (Please Mark **Y** for Yes or **N** for No in Each of the Following:)

1. ____ **Eyes** (glasses, contacts, cataracts, glaucoma, Etc.)
2. ____ **Ears, Mouth, Nose, Throat** (hearing loss, sinus, Etc.)
3. ____ **Cardiovascular** (heart, high b.p., high cholesterol, stroke)
4. ____ **Respiratory** (lungs, breathing, asthma, c.o.p.d., Etc.)
5. ____ **Neurological** (nerve issues, M.S., weakness, numbness, Etc.)
6. ____ **Endocrine** (thyroid, hormonal imbalances, liver, Etc.)
7. ____ **Constitutional** (fever, chills, nausea, dizziness, Etc.)
8. ____ **Hematological** (anemia, thin blood, sickle cell, Etc.)
9. _____ **Gastro-Intestinal** (acid reflux, ulcers, gall bladder, i.b.s., Etc.)
10. ____ **Genito-Urinary** (male/female reproduction, kidneys, bladder, Etc.)
11. ____ **Musculoskeletal** (breaks, arthritis, osteoporosis, discs, Etc.)
12. ____ **Skin** (rashes, skin cancer, dryness, psoriasis, eczema, hair, Etc.)
13. ____ **Psychiatric** (anxiety, depression, bipolar, add/adhd, Etc.)
14. ____ **Internal Organs** (diabetes, appendix, spleen, liver, Etc.)
15. ____ **Addictions** (Past or Present: alcohol, drugs, meds, Etc.)
16. ____ **Others**: _____

Please Describe in More Detail: _____

_____

Patient-Choice Treatment Options

Check ALL the Boxes Below That Corresponds How You Would Like the Doctors to Approach Your Issue(s):

- ☐ I simply wish to just have a few adjustments for symptom control, then call as needed.
- ☐ I would like the doctors to put me on a Treatment Plan to help me fully recover.
- ☐ I am interested in being shown any necessary Stretches +/- Exercises to help me heal faster.
- ☐ I would be open to Vitamin/Supplement or other Product recommendations to help my body through the healing phases.
- ☐ Once I complete my initial treatment plan, I'm interested in a Maintenance Adjustment Schedule to support my gains.

Patient Notes:

Doctor Notes:

C-sp:

*F	*FC
*E	*Lt.SD
*LR	*Rt.SD
*RR	*MFC
*LLF	*Lt.C
*RLF	*Rt.C

L-Sp:

*F	*Lt.SLR
*E	*Rt.SLR
*LR	*Bt.SLR
*RR	*SSU
*LLF	*Lt.Y
*RLF	*Rt.Y

Ht: Wt: BP:

Other:

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

D.C. Signature: _____ **Date:** _____