CONFIDENTIAL PATIENT HEALTH RECORD

Date:	I.D. #:

Who Referred You To Us? _____ **We do appreciate our referral supporters!**

Name: _____ D.O.B. _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: [Home]_____ [Cell] _____ [Work] _____ ☐Male ☐Female

E-Mail: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐ Separated

SSN: _____/_____/_____ Driver License #: _____ State: _____ Name of Spouse: _____

Employer: _____ ☐Self Employed Occupation: _____

Who, in addition to yourself, will be responsible for your bill? ☐Spouse ☐Workers Comp. ☐Auto Insurance ☐Medicare ☐Personal Health Insurance

Name of Insurance Co. _____ Ins. Card # / Claim #: _____

Name of the Insured if not yourself: ☐Self _____ D.O.B. of the Insured if not yourself: ☐Self _____

Contact Person, in case of Emergency: _____ Relationship: _____ Phone: _____

Tell Us Why You Are Here

Complaint / Concern: _____

_____

When were symptoms first experienced? _____ Onset: ☐Sudden ☐Gradual ☐Vague _____

Have you experienced prior similar complaint? ☐Y ☐N If so, explain _____

Is your current complaint the result of ☐Auto Accident ☐Work Injury ☐Home Injury ☐Sports Injury ☐Slip / Fall Injury ☐Lifestyle ☐Unknown

Date of Accident / Injury: _____ Describe: _____

Have you seen other healthcare professional(s) for this complaint? ☐Y ☐N Prior Chiropractic Treatment? ☐Y ☐N

If so, who? _____ When? _____

Treatment Received: _____ Outcome: _____

If so, who? _____ When? _____

Treatment Received: _____ Outcome: _____

If so, who? _____ When? _____

Treatment Received: _____ Outcome: _____

Are you taking Medications? ☐Y ☐N If so, please itemize _____

_____

Do you have any other health conditions / complaints other than that primary complaint for which you have sought our assistance? ☐Y ☐N

If so, please explain _____

_____

PAST HEALTH HISTORY

	Describe	When	Outcome
Major Surgery(ies)	_____	_____	_____
Major Surgery(ies)	_____	_____	_____
Significant Injury(ies)	_____	_____	_____
Significant Injury(ies)	_____	_____	_____
Hospitalization	_____	_____	_____
Hospitalization	_____	_____	_____

Below are 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 your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

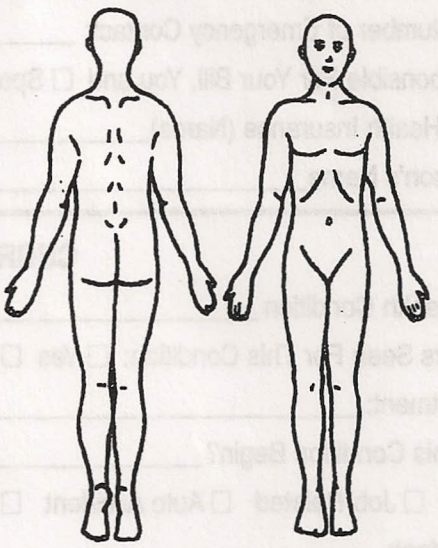
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature