Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ State: __________ Zip: __________

Home Phone #: ______________________ Birth Date: __________ Age: __________ Sex: ☐ M ☐ F

Cell Phone #: ______________________ Referred to this Office By: ______________________

Social Security #: ______________________ ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________ Is it ok to call you at work? ☐ Yes ☐ No

Name of Spouse: ______________________ Spouse's Employer: ______________________

Name and Number of Emergency Contact: ______________________ Relationship: __________

CURRENT HEALTH CONDITION

Reason For Your Visit: ______________________

Other Doctors Seen For This Condition: ☐ YES ☐ NO Who? ______________________

Type of Treatment: ______________________ Results: ______________________

When Did This Condition Begin? __________ Has This Condition Occurred Before? ☐ YES ☐ NO

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall Date of Accident: __________

Medications: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

☐ Other: ______________________

Do You Wear a Shoe Lift: ☐ YES ☐ NO

PAST HEALTH HISTORY

Have You Had Any Major Surgery or Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder

☐ Hernia ☐ Back Surgery ☐ Cesarean Section ☐ Other: ______________________

Major Accidents or Falls: ______________________ Broken Bones: ______________________

Hospitalization (other than above): ______________________

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: ______________________ Time Since Last Visit: ____

OVER ➡

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 your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

□ Cancer: ________	□ Mental Disorders	□ Whooping Cough	□ Rheumatic Fever
□ Heart Disease	□ Thyroid Disorders	□ Measles	□ Influenza
□ Stroke	□ Chicken Pox	□ Mumps	□ Polio
□ Diabetes	□ Pneumonia	□ Pleurisy	□ Anemia
□ Arthritis	□ Small Pox	□ Tuberculosis	□ Epilepsy

Are you pregnant? □ YES □ NO

Have you been tested HIV positive? □ YES □ NO

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

MUSCULO-SKELETAL
- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Leg Pain
- □ Other Problems:

____

____

NERVOUS SYSTEM
- □ Numbness: ______________
- □ Paralysis
- □ Dizziness
- □ Depression
- □ Fainting
- □ Convulsions
- □ Cold/Tingling Extremities

GENERAL
- □ Fatigue
- □ Allergies
- □ Migraines
- □ Fever
- □ Headaches

GASTRO-INTESTINAL
- □ Gall Bladder Problems
- □ Acid Reflux/Heartburn
- □ Colitis
- □ Abdominal Cramps
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Liver Problems
- □ Black/Bloody Stool

GENITO-URINARY
- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Discolored Urine
- □ Bed Wetting

FEMALE
- □ Menstrual Irregularity
- □ Severe Menstrual Cramps
- □ Breast Pain/Lumps

C-V-R CODE
- □ Chest Pain
- □ Short Breath
- □ High Blood Pressure
- □ Irregular Heartbeat
- □ Heart Problems
- □ Lung Problems/Congestion
- □ Varicose Veins

EENT
- □ Uncorrected Vision Problems
- □ Dental Problems
- □ Sore Throat
- □ Ear Aches
- □ Hearing Difficulty

PAIN SCALE: Please Circle

0 - No Pain

1

2

3

4

5

6

7

8

9

10 - Excruciating Pain

Please use the diagram to indicate your area(s) of pain.