Confidential Patient Health Record

Date:	**Patient I.D. Number:**

Patient Information

Name: _____ Address: _____

City: _____ State and Zip/Postal Code: _____

Home Phone: _____ Birthdate: _____ Age: _____ Sex: □ M □ F

Cell Phone: _____ Email: _____

Name of Emergency Contact: _____ Relationship: _____

Number of Emergency Contact: _____

Social Security Number: _____

Who is Responsible For Your Bill? Circle One: You and/or Spouse Worker's Comp Auto Ins.

Medicare Medicaid Personal Health Insurance (Name) _____ Policy #: _____

Social History

Circle One: Single Married Divorced Separated Widowed

Name and Number of Spouse if Applicable: _____

Employed? □ Yes □ No

Occupation? _____

Work in the home? □ Yes □ No

Number of Children: _____

Do you exercise?

□ Never □ Rarely □ Monthly □ Weekly □ Daily Type of Exercise(s): _____

Do you drink alcohol?

□ Never □ 1-2 per week □ 1-2 per day □ 2 or more per day □ Former

Do you use tobacco products?

□ Never □ Current every day smoker □ Current some day smoker □ Former

To be filled out by staff member only.

Blood Pressure.

Weight: _____ **Systolic: _____**

Height:_____ **Diastolic: _____**

Females Only:

When was your last period? _____

Are you pregnant or suspect pregnancy? _____

Current Health Condition

Unwanted Health Condition(s)/The Reason Why You Are Here Today:

_____

Other Doctors Seen For This Condition: □ Yes □ No Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin and how? _____

_____

_____

Have you ever had this condition before? □ Yes □ No If yes, when, and how many times? _____

The primary complaint is: □ Getting worse □ Is getting better □ Has not changed □ Intermittent

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: □ Yes □ No

Do you suffer from any condition other than that which you are now consulting us?

_____

Past Health History

Do you now or have you ever had any of the following conditions

□ **Hepatitis/HIV**

□ Anemia □ Arthritis □ Asthma □ Cardiovascular problems □ Cancer □ COPD □ Currently pregnant

□ Depression □ Diabetes □ Dislocation of _____ □ Dizziness/fainting □ Fractures

□ Headaches □ Heart disease □ High blood pressure □ Holter monitor

□ Kidney problems □ Low blood pressure □ Pacemaker □ Respiratory problems □ Seizures

□ Systemic disease □ Thyroid problems

Major accidents or Falls: _____

Previous surgeries/hospitalization/serious illnesses:

_____

Have you ever had general anesthesia: □ Yes □ No

Previous Chiropractic Care: □ Yes □ No

Doctor's Name and Date of Last Visit _____

Family Health History

*Please review the disease and conditions listed below. Indicate those that are **C (Current)** or **P (Past)** or **F (Fatal)** conditions. If no conditions apply, leave the spaces blank.*

If family health history is unknown, please write NA across the form.

Condition	Father: Age: Deceased: □ Yes □ No	Mother Age: Deceased: □ Yes □ No	Sibling(s)/Other Relatives
Arthritis			
Asthma			
Anemia			
Cancer (please specify)			
Cardiovascular problems			
COPD			
Depression			
Diabetes			
Dizziness/fainting			
Heart disease			
Hepatitis/HIV			
High blood pressure			
Hypertension			
Kidney disease			
Low blood pressure			
Respiratory problems			
Seizures			
Systemic disease			
TB			
Thyroid problems			
Stroke			

Other: _____

Allergies

Use the chart below to list all allergens and reaction. Example: Bee stings reaction: hives

Allergen	Severity: Mild, Moderate, or Severe	Reaction

Medication History

Current Mediations and History

*Use the cart below to list ALL the brand-name and generic prescription medications you currently take. Be sure to fill in ALL the information for each medication. The dosage appears on each pill bottle on the prescription label in milligrams (m.g.). This is called the dose, or strength. The label on liquids and shots list the dose too. Use the back of this sheet or additional pages for additional medications. *You may also provide us with a hard copy list of the medications you are on.*

Medication Name	Prescribing Doctor	Reason for taking the medication	Dose (such as 2 mg, 1 tsp)	How often? (Such as 2x/day)

Nonprescription medications, vitamins, and supplements

List all those that you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin, fish oil or other nutritional supplements. Include any herbs or alternative medicines you take. Please fill in all the fields!

Name	Reason for taking	Dose (Such as 500mg)	How often?

Medical History Problems/Review of Systems

☐ No, I do not have any significant past medical problems

☐ Yes, I have experienced or am currently experiencing the problems indicated below

Constitutional

☐ Asthma
☐ Food allergies
☐ Frequent sinus problems
☐ Hay fever
☐ Hives
☐ Erectile dysfunction
☐ Low libido

Cardiovascular

☐ An unusually slow pulse
☐ Angina (pain over the heart
☐ Blue extremities
☐ Cold hands/feet
☐ Feeling light-headed when standing
☐ Heart murmur
☐ Heart problems
☐ High blood pressure
☐ Leg pain walking short distances
☐ Low blood pressure
☐ Palpitations (heart skipping beats)
☐ Rapid heart beat
☐ Sores that don't heal
☐ Taking nitroglycerine
☐ Varicose veins

Ears

☐ Chills ☐ Difficulty concentrating ☐ Difficulty sleeping ☐ Dizzy spells
☐ Fainting ☐ Fatigue ☐ Fever ☐ Memory trouble
☐ Nausea ☐ Nervousness ☐ Night sweats ☐ Side effects from medication
☐ Weakness ☐ Weight change

Ears, Nose, & Threat

☐ Anosmia (loss of smell) ☐ Bleeding gums ☐ Blisters/cold sores ☐ Dental problems
☐ Deviated septum ☐ Dry mouth ☐ Dysphasia ☐ Ear discharge
☐ Ear noises/ringing ☐ Ear pain ☐ Excessive saliva ☐ Frequent colds
☐ Gum disease ☐ Halitosis ☐ Hearing loss ☐ Loss of teeth
☐ Motion sickness ☐ Nasal breathing problems ☐ Nasal drip
☐ Nasal polyps ☐ Nose bleeds ☐ Nose runs constantly ☐ Punctured ear drum
☐ Recurrent ear infections ☐ Sinus infections ☐ Sinus pain ☐ Sneezing spells
☐ Sore throat ☐ Sore tongue ☐ Sores or cracks at mouth corners
☐ Sores/ulcers ☐ Swollen glands ☐ Tongue badly coated ☐ Tonsilitis
☐ Vertigo/dizziness

Endocrine

☐ A loss of appetite ☐ Being tired most of the time ☐ Being unusually jumpy or nervous
☐ Changes in hair growth or distribution ☐ Cold intolerance
☐ Excessive hunger ☐ Excessive thirst ☐ Extreme thinness
☐ Feeling drowsy after eating ☐ Feeling generally weak
☐ Feeling shaky or faint when hungry ☐ Having diabetes
☐ Heat intolerance ☐ Hoarseness ☐ Needing to eat to relieve fatigue
☐ Unexplained weight gain ☐ Unexplained weight loss

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Eyes

- A burning sensation in the eye
- An injury to the eyes
- Blurred vision
- Cataracts
- Crossed eyes
- Dry or gritty eyes
- Far slightness
- Feeling/ seeing a heart beat in the eye
- Glaucoma
- Itchy eyes
- Near sightedness
- Redness
- Swelling
- Tearing/crusting
- Vision headaches

Gastrointestinal

- Acid reflux
- Belching or burping after meals
- Black or bloody stools
- Constipation
- Diarrhea
- Difficulty swallowing
- Frequent indigestion
- Frequent vomiting
- Gall bladder disease
- Having one or less bowel movements
- Heartburn
- Hemorrhoids
- Intestinal worms
- Liver trouble
- Needing laxatives or stool softeners
- Pain or indigestion after eating greasy foods
- Pale or yellow stools
- Stomach ulcers
- Straining during bowel movements

Genitourinary

- A discharge other than urine
- Bed wetting
- Bladder control problems
- Burning
- Cloudy or foul-smelling urine
- Difficulty starting a stream
- Discolored urine
- Dribbling
- Frequent urination
- Getting up at night to urinate
- Having a small caliber stream
- Kidney or bladder infections
- Kidney stones
- Painful urination
- Scanty Urination
- Urgency

Integumentary

- Acne
- Boils
- Bruising
- Coarse or bumpy skin
- Corns
- Dandruff
- Dryness
- Eczema
- Excessive perspiration
- Hair changes
- Itching
- Nail bed changes
- Nail fungus
- Plantar warts
- Psoriasis
- Rashes
- Sores

Musculoskeletal

- Back injuries
- Back pain
- Frequent foot cramps
- General muscle tension
- Heel spurs
- Hot joints
- Joint pain
- Joint stiffness
- Joint swelling
- Leg cramps during the day
- Leg cramps at night
- Muscle cramps
- Muscle tenderness
- Muscle twitching
- Neck injuries
- Neck pain
- Osteoarthritis
- Pain between the shoulders
- Painful feet
- Rheumatism
- Shoulder/arm pain
- Spinal curvature
- Tender ribs
- Tenderness over a bone

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Neurological

- ☐ Confusion
- ☐ Convulsions
- ☐ Difficulty of speech
- ☐ Dizziness/vertigo
- ☐ Double vision
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Forgetfulness
- ☐ Hand trembling
- ☐ Headaches
- ☐ Incoordination
- ☐ Losing consciousness
- ☐ Loss of feeling
- ☐ Loss of memory
- ☐ Meningitis
- ☐ Muscle jerking/twitching/tics
- ☐ Numbness/tingling
- ☐ Paralysis
- ☐ Stuttering

Psychiatric

- ☐ Alcoholism
- ☐ Anxiety
- ☐ Being timid or shy
- ☐ Considerable emotional stress
- ☐ Crying often
- ☐ Drug addictions or dependency
- ☐ Eating when nervous
- ☐ Extreme worry
- ☐ Feeling angered or irritable
- ☐ Feeling miserable or blue
- ☐ Frequent hyperventilation
- ☐ Hallucinations
- ☐ Insecurity
- ☐ Nail biting
- ☐ Phobias
- ☐ Recurrent bad dreams
- ☐ Sleep walking
- ☐ Suicidal thoughts

Respirator

- ☐ A chronic chest conditions
- ☐ Asbestos exposure
- ☐ Chronic cough
- ☐ Congestion
- ☐ Coughing up blood
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Non-productive (dry) cough
- ☐ Pain upon breathing
- ☐ Pain upon expiration
- ☐ Pain upon inspiration
- ☐ Phlegm
- ☐ Productive cough
- ☐ Severe colds
- ☐ Short of breath
- ☐ Wheezing

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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouses Signature of Authorizing Care _____

Date _____