

Confidential Patient Health Record

Date: _____ Acct # (Office Only) _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birth Date: _____ Social Security #: _____

Business Employer: _____ Work Phone: _____

Name of Spouse/Guardian: _____ Referred to this office by: _____

Personal Health Insurance Name: _____ Full Name of Insured: _____

Birth Date of Primary Insured: _____

Name of Your Primary Care Physician: _____ Phone #: _____

Current Health Condition

What is your height? _____ ft. _____ inches What is your weight? _____ lbs.

What was the date when this condition began? _____

Has this condition occurred before? YES NO

How did this condition happen or begin?

What are your complaints/problems with this condition:

Have you seen any other Doctors for this condition? YES NO

If yes, please tell us who: _____ Results: _____

Previous Chiropractic Care: YES NO If yes, tell us who: _____

Drugs you now take:

Vitamins/Supplements you take:

Previous Surgeries:

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please circle the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Circle here if you want the Doctor to select

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. The patient also agrees that he/she is responsible for all bills incurred at this office regardless of any judgment, verdict or settlement. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

(Signature/Patient or Legal Guardian) _____ Date _____

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 chiropractic 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 IN THE PAST 6 MONTHS:

MUSCULOSKELETAL

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

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

FEMALES ONLY:

Are you pregnant?
 Yes No Not Sure

NERVOUS SYSTEM

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

GENITOURINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIOVASCULAR

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

GENERAL

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

EENT

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

GASTROINTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

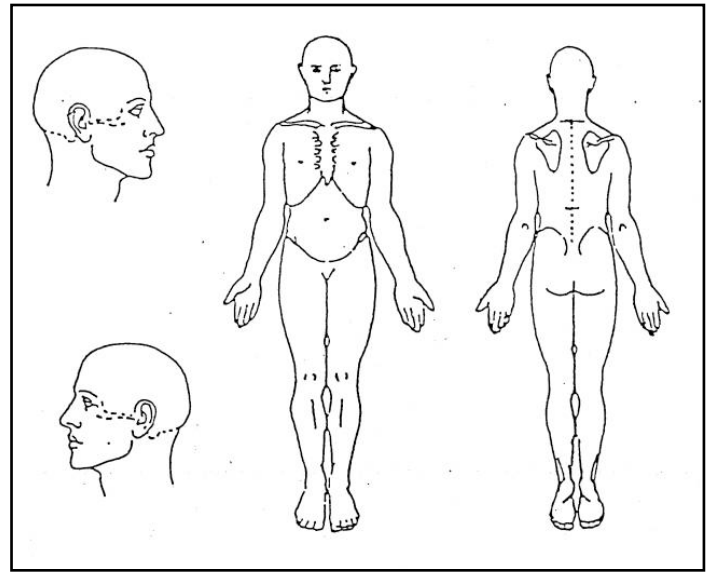
MALE/FEMALE

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

FAMILY HISTORY

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

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



Please outline on the Diagram the area(s) of your discomfort.

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:
DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature