

Patient Name: _____

Date: _____

Confidential Patient Health Record

Today's Date: ___/___/_____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

Title: Mr. Ms. Mrs.

Last: _____ First: _____ Middle: _____

Suffix: Jr Sr II III

Birth Date: ___/___/_____ Age: _____ Sex: Male / Female SSN: _____

Marital Status: Single Married Widowed Divorced Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Home Phone: (_____) _____ - _____ ext _____ Work Phone: (_____) _____ - _____ ext _____

Cell Phone: (_____) _____ - _____ ext _____ Fax #: (_____) _____ - _____ ext _____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: Spouse Relative Friend Other _____

Home Phone: (_____) _____ - _____ ext _____ Cell Phone: (_____) _____ - _____ ext _____

Work Phone: (_____) _____ - _____ ext _____

Employment Information

Business Name: _____

Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

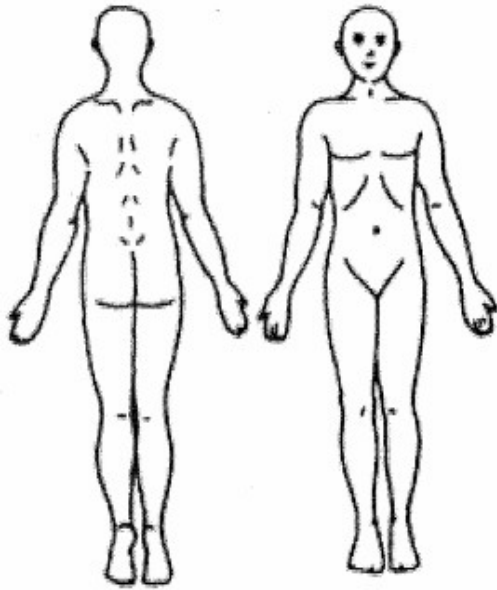
PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

Patient Name: _____

Date: _____



When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- chills fatigue night sweats weight loss
- daytime drowsiness fever weight gain

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- blindness change in vision field cuts photophobia
- blurred vision double vision glaucoma tearing
- cataracts eye pain itching wear glasses/contacts

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

Patient Name: _____

Date: _____

- bleed- ear drainage hearing loss nosebleeds sore throat
- ing
- den- ear pain history of head injury postnasal drip tinnitus (ringing in ears)
- tures
- diffi- fainting hoarseness rhinorrhea (runny nose) TMJ problems
- culty
- s w a l - lowing
- dis- frequent sore throats loss of sense of smell sinus infections
- charge
- dizzi- headaches nasal congestion snoring
- ness

Respiration: I DENY having any of the symptoms or problems listed below.

- asthma coughing up blood sputum production
- cough shortness of breath wheezing

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort) high blood pressure shortness of breath with exertion or exercise
- chest pain low blood pressure swelling of legs
- claudication (leg pain/ache) orthopnea (difficulty breathing lying down) ulcers
- heart murmur palpitations varicose veins
- heart problems paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- abdomi- diarrhea indigestion abnormal stool caliber vomiting blood
- nal pain
- belching difficulty swallowing jaundice abnormal stool color
- black - heartburn nausea abnormal stool consistency
- t a r r y stools
- constipa- hemorrhoids rectal bleeding vomiting
- tion

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

Patient Name: _____

Date: _____

- birth control cramps irregular menstruation vaginal bleeding
 breast lumps / pain frequent urination pregnancy vaginal discharge
 burn- ing uri- nation hormone therapy urine retention

Male: I DENY having any of the symptoms or problems listed below.

- burning urination frequent urination prostate problems
 erectile dysfunction hesitancy/ dribbling urine retention

Endocrine: I DENY having any of the symptoms or problems listed below.

- cold intolerance excessive hunger goiter unusual hair growth
 diabetes excessive thirst hair loss voice changes
 excessive appetite abnormal frequency of urination heat intolerance

Skin: I DENY having any of the symptoms or problems listed below.

- changes in nail texture hair loss itching skin lesions / ulcers
 changes in skin color hives paresthesias varicosities
 hair growth history of skin disorders rash

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness limb weakness numbness slurred speech tremor
 facial weakness loss of consciousness seizures stress unsteadiness of gait/ loss of balance
 headache loss of memory sleep disturbance strokes

Psychologic: I DENY having any of the symptoms or problems listed below.

- anhedonia behavioral change convulsions memory loss
 anxiety bi-polar disorder depression mood change
 loss or change in appetite confusion insomnia

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis itching chronic nasal congestion sneezing
 food intolerance acute nasal congestion rash

Hematologic: I DENY having any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
 bleeding blood transfusion fatigue

Patient Name: _____

Date: _____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD chicken pox headaches scoliosis
- atopic dermatitis (eczema) crohn's/colitis hepatitis seizure disorder
- allergies/hayfever depression HIV sickle cell anemia
- anemia diabetes measles spina bifida
- asthma ear infections mumps other:
- bedwetting fetal drug exposure psoriasis
- cerebral palsy food allergies (list below) rash

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

Patient Name: _____

Date: _____

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alz-heimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthri-tis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cere-bral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

Patient Name: _____

Date: _____

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- angioplasty cosmetic hysterectomy pacemaker insertion
- appendectomy D & C joint reconstruction rotator cuff
- caesarian sec- dental surgery joint replacement spinal fusion
tion
- cardiac cathe- gall bladder knee repair tonsilectomy
terization
- carpal tunnel hemorrhoidectomy laminectomy other:
- coronary artery hernia repair mastectomy
bypass

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury head injury (loss of consciousness) motor vehicle accident
- broken bones head injury (no loss of consciousness) soft tissue injury (mild)
- disability (ies) industrial accident soft tissue injury (moderate)
- fall (severe) joint injury soft tissue injury (severe)
- fracture laceration (severe) other:

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

- | | | | | | |
|--|--------------------------------|-----------------------------------|---|---|--|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| paternal grand-
father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| paternal grand-
mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| m a t e r n a l
grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| m a t e r n a l
grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> _____ h a s /
had: _____ |

Insurance Information:

Who Is Responsible For Your Bill? YOU and... (mark appropriate box(es)) Myself ONLY

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____

Patient Name: _____

Date: _____

Personal Health Insurance Carrier: _____

Health ID Card #: _____

Policy Holder's Name: _____

Group #: _____

Policy Holder's Date of Birth: ____ - ____ - ____

Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____ Time: _____ am/pm

Carrier: _____

Policy # _____

Carriers Phone #: (____) _____ - _____

Adjuster: _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____

Date: _____

Patient's Signature: _____

Date: _____

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Case: _____ Date: _____ Dr: _____

Chief Complaint: _____

Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New → Acute or Chronic

Recurrence (Acute) Exacerbation (Acute) Chronic

Mechanism of Onset:

Auto: Driver/Passenger Pedestrian (refer to completed auto accident history form)

Work Related: Fall Falling Object Lifting Overexertion Repetitive Motion Other: _____

Other – Liability: Slip or Fall Other: _____

Other – No Liability: Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall

No Injury

Description of Onset of Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness

Location: Left / Right / Bilateral _____

Quality: Burning Diffuse Dull/Aching Localized Radiating Sharp Shooting

Stabbing Throbbing Tightness Tingling Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: _____

Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____

Worsened: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: *Worse:* Morning Afternoon Night with Activity; Constant Intermittent

Context: *Better with:* Warm Temp Cold Temp *Worse with:* Warm Temp Cold Temp Damp

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swing

Localized Tingling Nausea Ringing in Ears Sleep Disturbance Stiffness

Headaches: Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus

Quality: Dull Sharp Throbbing Stabbing Aura No Aura

Types: Hat Band Cluster Migraine Tension

Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

- | | | | | |
|---------------------------------------|--|--|--|---|
| <input type="checkbox"/> aches | <input type="checkbox"/> burning | <input type="checkbox"/> cold limb(s) | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> ecchymosis | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> heartburn | <input type="checkbox"/> joint stiffness |
| <input type="checkbox"/> muscle spasm | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> nausea | <input type="checkbox"/> numbness | <input type="checkbox"/> pale bluish skin |
| <input type="checkbox"/> panic | <input type="checkbox"/> pins & needles | <input type="checkbox"/> rhinorrhea (runny nose) | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sweating |
| <input type="checkbox"/> swelling | <input type="checkbox"/> tingling | <input type="checkbox"/> vomiting | | |

Modifying Factors:

Symptoms Better With: nothing helps activity bending applying cold applying heat

massage movement OTC meds Rx meds rest

stretching sitting standing twisting walking

Symptoms Worse With: (as noted in Social History)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn–Sit-Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)

Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Lifting Postures: with Arms High Near from Knee Off Posture from Torso

Work Activity Postures: (hrs/day)

bending: _____ h/d climbing: _____ h/d kneeling: _____ h/d pulling: _____ h/d pushing: _____ h/d

reaching: _____ h/d sitting: _____ h/d standing: _____ h/d twisting: _____ h/d walking: _____ h/d

Repetitive Activities: (hrs/day)

assembly/fine manipu- computer use/typing: _____ h/d grasping: _____ h/d
lation: _____ h/d

hand tool use: _____ operation of machinery controls: _____ h/d phone use: _____ h/d
h/d

Condition’s Effect On Job Performance:

Mild Painful (Can do) Mod Painful (limited ability) Mod/Sev Limited Duty Sev No Limited Duty Sev (can’t do limited duty)

Recreational Activity: Effects of Current Condition on Performance

_____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

_____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform