Confidental Patient Health Record

Date	I.D. NO.

PERSONAL HISTORY

Name:_____ Address:_____
City:_____ State:_____
Home Phone_____ Birth Date:_____
Social Security #_____ Driver's License Number:_____
Check One: __ Married __ Single __ Widowed __ Divorced__ Separated E-mail_____
Business Empolyer: _____ Type of Work:_____
Business Phone:_____ Spouse's Social Security#_____
Name Spouse:_____
Spouse's Empolyer:_____ Business Phone:_____
Type of Work:_____ Names and Ages of Children_____
Referred to office by:_____
Name of Emergency Contact:_____ Phone#_____ Relationship_____
How will your payments be made? __ Cash __ Check __ Credit Card
Personal Health Insurance Carrier_____ Policy and/or Group #_____
_____

CURRENT HEALTH CONITION

Purpose of This Appointment _____
Other Doctors Seen For This Condition: __ Yes __ No Who?_____
Type of Treatment:_____ Results:_____
When Did This Condition Begin?_____ Has This Condition Occured Before _ YES _ No
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 Empolyer?: __ Yes __ No
Drugs You Now Take: __ Nerve Pills __ Pain Killers/Muscle Relaxers __ Blood Pressure Medicine __ Insulin __ Other _____
Do You Wear A Shoe Lift? __ Yes __ No
Do You Suffer From Any Condition Other Than Which You Are now Consulting Us?_____
_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: __ Appendectomy __ Tonsillectomy __ Gall Bladder __ Hernia __ Back Surgery __ Broken Bones __ Other _____

Major Accident or Falls:_____
_____

Hospitalization (Other Than Above) _____
_____

Previous Chiropractic Care: __ None __ Doctor's Name & Appoximate Date of Last Visit_____
_____

Below are a list of disease which may seen unrelated to the purpose of your appointment. However, these 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

MUSCULO-SKELETAL CODE
__ Low Back Pain
__ Pain Between Shoulders
__ Neck Pain
__ Arms Pain
__ Joint Pain/Stiffness
__ Walking Problems
__ Difficult Chewing/Clicking Jaw
__ General Stiffness

__ Nervous
__ Numbness
__ Paralysis
__ Dizziness
__ Forgetfulness
__ Confusion/Depression
__ Fainting
__ Convulsions
__ Cold/Tingling Extremities
__ Stress
__ Pins and Needles in Arms
__ Pins and Needles in Legs

GASTRO-INTESTINAL CODE
__ Poor/Excessive Appetite
__ Excessive Thirst
__ Frequent Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Gas/Bloating After Meals
__ Heartburn
__ Black/Bloody Stool
__ Colitis

C-V-R CODE
__ Chest Pain
__ Short Breath
__ Blood Pressure Problem
__ Irregular Heart
__ Heart problems
__ Lungs Problems/Congestion
__ Various Veins
__ Ankle Swelling
__ Stroke
__ Cold Hands
__ Cold Feet

FEMALES ONLY
When was your last period?_____

Are you pregnant?
__ Yes __ No __ Not Sure

GENITO-URINARY CODE
__ Bladder Trouble
__ Painful/Excessive Urination
__ Discolored Urine

MALE/FEMALE CODE
__ Menstrual Irregularity
__ Menstrual Cramps
__ Vaginal Pain/Infection
__ Breast pain/Lumps
__ Prostate/Sexual Dysfunction
__ Other Problems
_____
_____
_____
_____

GENRAL CODE
__ Fatigue
__ Allergies
__ Loss of Sleep
__ Fever
__ Headaches

__ Liver Problems
__ Gall Bladder Problems
__ Weight trouble
__ Abdominal Cramps

EENT CODE
__ Vision Problems
__ Dental Problems
__ Sore Throat
__ Ear Aches
__ Hearing Difficulty
__ Stuffed nose

FAMILY HISTORY
The following members have a same/similar problems as I do:
__ Mother
__ Father
__ Brother
__ Sister
__ Spouse
__ Child