PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name____

Address____

City______________________________ State______________

Zip _________________Home phone __________________

Birth date _______________ Cell Phone___________________

Age ___________ Gender _______ Number of children ______

Employer____

Work address ____

Work phone ____

Type of work ____

Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner

Social Security # ____________________________________

E-mail address_______________________________________

Payment method ❑ Cash ❑ Check ❑ Credit card ❑ Insurance

ABOUT YOUR PARTNER

Name ______________________________________

Employer ___________________________________

Work phone _________________________________

Type of work ________________________________

HEALTH HABITS

	No	Yes
Do you smoke?	❑	❑
Do you drink alcohol?	❑	❑
Do you drink coffee, tea or soda?	❑	❑
Do you exercise regularly? ❑ Home ❑ Gym	❑	❑

If not, why? ❑ Intimidated ❑Time ❑Schedule❑ Cost

Do you wear:

❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

REASON FOR THIS VISIT

Describe the purpose of this visit _______________________

____

Is the purpose of this appointment related to:

❑ Job ❑ Sports ❑ Auto ❑ Fall

❑ Home Injury ❑ Chronic Discomfort ❑ Other

If job related, have you made a report of your accident to your employer? ❑ Yes ❑ No

Where specifically is the problem located? _______________

When did this condition begin? ________________________

Has this condition

❑ Gotten worse ❑ Stayed constant ❑ Comes and goes

Does this condition interfere with?

❑ Work ❑ Sleep ❑ Daily routine ❑ Other activities

Please explain ______________________________________

Has this condition occurred before? ❑ Yes ❑ No

Please explain ______________________________________

Have you seen other doctors for this condition? ❑ Yes ❑ No

Doctor's Name(s) ___________________________________

Type of treatment ___________________________________

Results ____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ________________________________

Have you heard about us in/on: __Paper __Clinic Sign __Yellow Pages

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Have you been to a Chiropractor this year? ❑ Yes ❑ No

Approximate date of last visit ___________________________________

Reason for those visits: _______________________________________

Doctor's name ____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- Doctors of Chiropractic work with the nervous system? ❑ Yes ❑ No
- The nervous system controls all bodily functions and systems? ❑ Yes ❑ No
- Chiropractic is the largest natural healing profession in the world? ❑ Yes ❑ No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❑ Yes ❑ No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ **Relief care** – Symptomatic relief of pain or discomfort

❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition.

____ _______________________________

Patient's signature Date

IMPORTANT QUESTIONS

I sleep on my: ❑ Side ❑ Back ❑ Stomach ❑ Move around

I sit a lot: ❑ Yes ❑ No

I seem to get sick a lot: ❑ Yes ❑ No

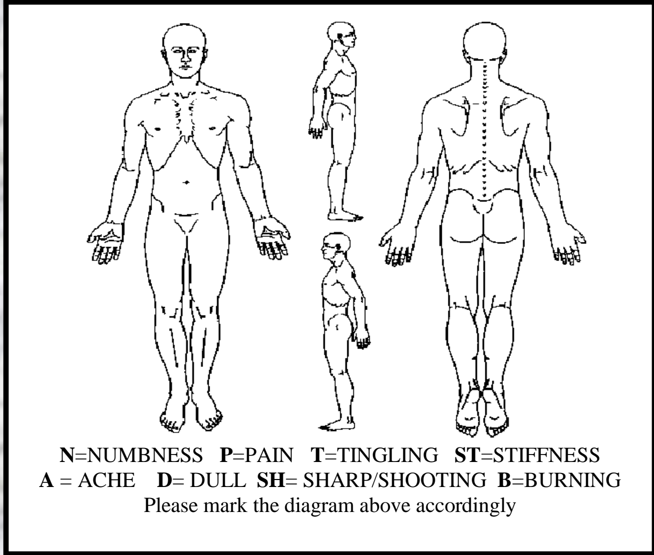
Are you confused by Nutritional Supplements: ❑ Yes ❑ No

If so, would you like a consultation: ❑ Yes ❑ No

I am interested in rehabilitation services which may help speed my recovery: ❑ Yes ❑ No

If not, why? ❑ Time ❑ Schedule ❑ Cost

I am interested in: ❑ Ion Cleanse ❑ Infrared Sauna ❑ Massage beds ❑ Weight-Loss



N=NUMBNESS **P**=PAIN **T**=TINGLING **ST**=STIFFNESS
A = ACHE **D**= DULL **SH**= SHARP/SHOOTING **B**=BURNING
Please mark the diagram above accordingly

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

❑ Severe or frequent headaches
❑ Sinus problems
❑ Dizziness
❑ Loss of sleep
❑ Pain between shoulders
❑ Frequent neck pain
❑ Numbness in Arms/legs/hands
❑ Pain in Arms/legs/hands
❑ Lower back problems
❑ Digestive problems

❑ Heart surgery/ Pacemaker
❑ Heart attack/stroke
❑ Heart murmur
❑ Congenital heart defect
❑ High/Low blood pressure
❑ Difficulty breathing
❑ Asthma
❑ Tuberculosis
❑ Alcohol/drug abuse
❑ Venereal disease
❑ HIV/AIDS
❑ Ulcers/Colitis

❑ Arthritis
❑ Diabetes
❑ Shingles
❑ Kidney problems
❑ Hepatitis
❑ Cancer
❑ Chemotherapy
❑ Rheumatic fever
❑ Psychiatric problems
❑ Thyroid problems
❑ Surgeries
❑ ________________
❑ ________________

For women:

Are you pregnant? ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No
Are you taking birth control? ❑ Yes ❑ No
Do you experience painful periods? ❑ Yes ❑ No
Do you have irregular cycles? ❑ Yes ❑ No
Do you have breast implants? ❑ Yes ❑ No

I am interested in supporting my condition(s) with nutritional supplements

❑ Yes ❑ No

If YES, would you like support for: ❑ All above OR ❑ Only specific conditions:______________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further agree to pay all collection fees and interest should I not make required payments.

Signature: ____Date:__________________