

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

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 _____

ABOUT YOUR PARTNER

Name _____

Employer _____

Work phone _____

Type of work _____

HEALTH HABITS

	No	Yes
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Do you smoke? No Yes

Do you drink alcohol? No Yes

Do you drink coffee, tea or soda? No Yes

Do you exercise regularly? No Yes

Do you wear:

Heel lifts Sole lifts Inner soles Arch supports

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

Reason for those visits? _____

Doctor's name _____

Approximate date of last visit _____

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.

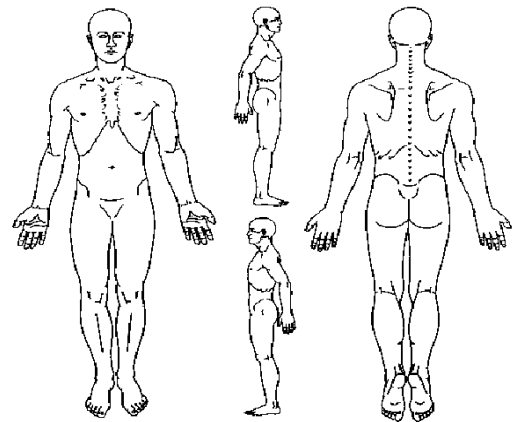
Patient's signature

Date

MEDICATIONS I NOW TAKE

- Cholestral medication
- Stimulants Blood thinners
- Tranquilizers Pain killers (including aspirin)
- Muscle relaxers _____
- Insulin _____

Vitamins & Supplements I now take: _____



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.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/
Pacemaker | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Diabetes | For women: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Kidney problems | Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hepatitis | Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cancer | Do you experience painful periods? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Numbness in Arms/legs/hands | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemotherapy | Do you have irregular cycles? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain in Arms/legs/hands | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever | Do you have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Psychiatric problems | |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Thyroid problems | |
| | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Surgeries | |
| | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> _____ | |
| | | <input type="checkbox"/> _____ | |

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: _____