PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name ____

Address ____

City _________________ State ______ Zip ___________

Home phone __________________ Birth date __________

Cell Phone________________ Work Phone ____________

Email ____

Occupation _______________________________________

Employer____

Work address _____________________________________

Marital Status ____________________________________

Do you have any children? Ages ____________________

Social Security # __________________________________

Health Insurance __________________________________

ABOUT YOUR SIGNIFICANT OTHER

Name____

Employer ____

Work phone ______________________________________

Occupation _______________________________________

REASON FOR THIS VISIT

Describe the purpose of this visit __________________

____

When did this condition begin? ___________________

What makes it better? __________________________

What makes it worse? ___________________________

Does the pain

❑ Stay in one spot ❑ Radiate to other areas

Type of pain

❑ Sharp with motion ❑ Deep burning

❑ Dull ache ❑ Throbbing

Has this condition

❑ Gotten worse ❑ Stayed constant ❑ Comes and goes

Does this condition interfere with

❑ Work ❑ Sleep ❑ Daily routine ❑ Other activites

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 ____________________________________

Any other recent health concerns? ________________

____

MEDICATIONS I NOW TAKE

❑ Nerve pills ❑ Stimulants

❑ Blood thinners ❑ Tranquilizers

❑ Muscle relaxer ❑ Insulin

❑ Blood pressure medicine

❑ Pain killers (including aspirin)

❑ None

❑ _____________________

❑ _____________________

❑ _____________________

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ___________________________

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

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

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 analysis, 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
- ❑ HIV/AIDS
- ❑ _________________

- ❑ Heart surgery/ pacemaker
- ❑ Heart attack/stroke
- ❑ Heart murmur
- ❑ Congenital heart defect
- ❑ High/Low blood pressure
- ❑ Difficulty breathing
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Alcohol/drug abuse
- ❑ Surgeries
- ❑ Digestive problems
- ❑ _________________

- ❑ Arthritis
- ❑ Diabetes
- ❑ Shingles
- ❑ Kidney problems
- ❑ Hepatitis
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Rheumatic fever
- ❑ Psychiatric problems
- ❑ Thyroid problems
- ❑ Lower back problems
- ❑ Ulcers/Colitis
- ❑ _________________

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

CURRENT LIFESTYLE

Physical	**No**	**Yes**
Do you exercise regularly?	❑	❑
Are you stretching daily?	❑	❑
Are you interested in exercise?	❑	❑
Do you pay attention to posture?	❑	❑

Bio-Chemical	**No**	**Yes**
Do you eat prepared, processed or fast foods?	❑	❑
Do you smoke?	❑	❑
Do you consume caffeinated, carbonated, or drinks high in sugar daily?	❑	❑
Do you take nutritional supplements?	❑	❑

Mental/ Emotional	**No**	**Yes**
Do you feel "stressed out" regularly?	❑	❑
Do you practice relaxation/meditation techniques daily?	❑	❑
Do you handle stress in a positive way?	❑	❑
Is lack of time and/or energy during the day a source of stress for you?	❑	❑

GOALS FOR MY HEALTH

Would you like help with:

	No	**Yes**
Improving Posture	❑	❑
Exercise	❑	❑
Nutrition	❑	❑
Meditation	❑	❑
Stress Reduction	❑	❑
Weight Loss	❑	❑
Flexibility	❑	❑
Reducing Current Medications	❑	❑

Additional Health Goals or Comments:

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I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature:____Date:_____________