Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name:_____ Address:_____

City: _____ State/Prov: _____ Zip/Postal Code:_____

Home Phone: _____ Birth Date:_____ Age:___ Sex: ☐ M ☐ F

Cell Phone:_____ Driver's Licence Number: _____

Business Employer:_____ Circle One: Married Single Widowed Divorced Separated

Business Phone:_____ Type of Work:_____

Name of Spouse: _____ Business Phone_____

Spouse's Employer _____ Name and Ages of Children_____

Type of Work _____ _____

Referred To This Office By:_____

Name and Number of Emergency Contact:_____ Relationship:_____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid

___Personal Health Insurance (Name) _____☐ Health Card #_____

CURRENT HEALTH CONDITION

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 Occurred 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 Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Other _____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

_____

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐Hernia ☐Back Surgery

☐Broken Bones ☐Other _____

Major Accidents or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐None ☐Doctor's Name & Approximate Date of List Visit_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions 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 ever tested HIV positive?____ Yes _____No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

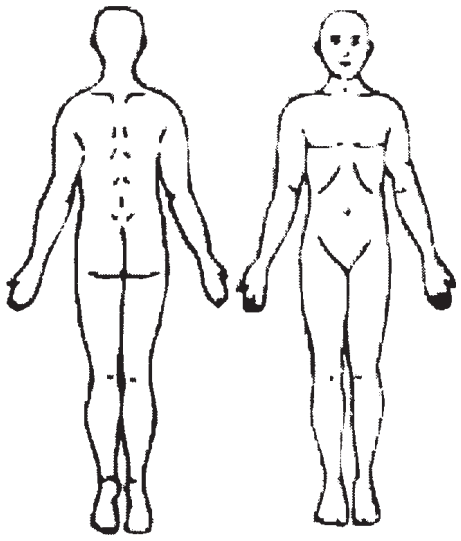
_____
_____
_____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

Yes No Not sure



Please outline on the diagram the area of your discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

_____

Patient Accepted: Yes No Referred

_____

Doctor's Signature

ACCIDENT DESCRIPTION

Why Chiropractic? People go to Chiropractics for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). 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	Corrective Care	Check here if you want the Doctor to select the type of care appropriate for your condition.

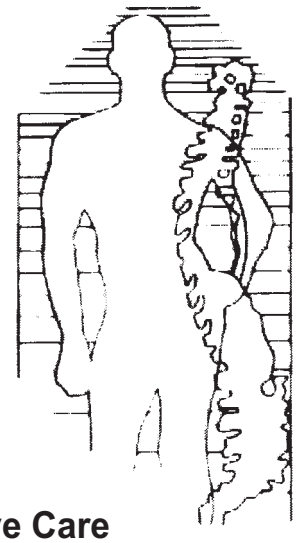
Date _____

Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!

Relief Care

Relief care is that necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in its length or time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature X_____ Date _____

Guardian or Spouse's
Signature Authorizing Care_____ Date _____