



Confidential Patient Health Record

First Visit Date: ___/___/___

How did you hear about us? [] Family [] Friend [] Co-Worker [] Close to home/work [] Dr. [] Yellow pages [] Drove by [] Hospital [] Screening/Radio/TV

Personal Information

Last: ___ First: ___ Middle: ___

Birth Date: ___/___/___ Age: ___ Sex: Male/ Female SSN ___ - ___ - ___

Driver's License #: ___ State: ___

Marital Status: [] Single [] Married [] Widowed [] Divorced [] Separated

Address: ___ Apt # ___

City: ___ State: ___ Zip: ___

Home Phone: (___) ___ - ___ Work Phone: (___) ___ - ___ ext ___

Cell Phone: (___) ___ - ___ Message/Voice Mail #: (___) ___ - ___ (Important for appointment reminders)

Email Address: ___ Spouses Name: ___ (Office use only for healthcare newsletters)

Children (Names and Ages): ___

Emergency Contact

Last: ___ First: ___ Middle: ___

Relationship: [] Spouse [] Relative [] Friend [] Other

Home Phone: (___) ___ - ___ Cell Phone: (___) ___ - ___

Work Phone: (___) ___ - ___ ext ___

Employment Information

Business Name: ___

Address: ___ Apt # ___

City: ___ State: ___ Zip: ___

Occupation/Job Title: ___ Job Description: ___

Mark the highest level of Education completed:

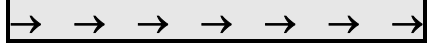
- [] high school [] college [] doctorate

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters **BELOW** to indicate the **TYPE** and **LOCATION** of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



**Key: A = Ache B = Burning
P = Pain N = Numbness**

When did this Condition **BEGIN**? ____/____/____

Has it ever occurred before? Yes No. When? _____

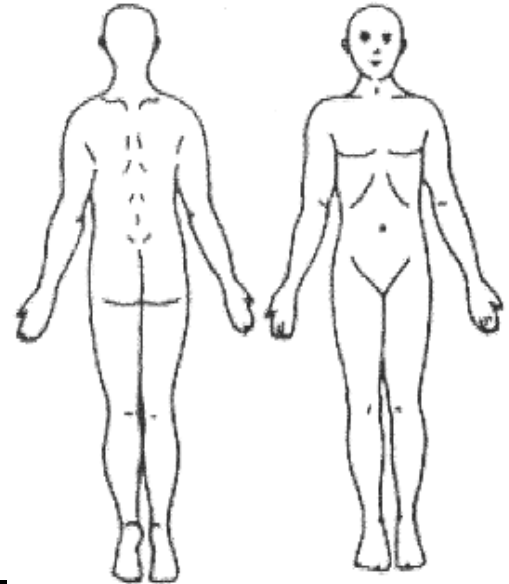
Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Do you **SUFFER** with **ANY OTHER** Condition than which you are now consulting us?



REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

If you have **NONE** of the listed symptoms, check "I DENY".

Otherwise, please check the symptoms you have experienced in the past twelve (12) months.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- chills fatigue night sweats weight loss
- daytime drowsiness fever weight gain

Eyes/Vision: I DENY having or have had any of the symptoms or problems listed below.

- blindness change in vision field cuts photophobia
- blurred vision double vision glaucoma tearing
- cataracts eye pain itching wear glasses/contacts

Ears, Nose and Throat: I DENY having or have had any of the symptoms or problems listed below.

- bleeding ear drainage hearing loss nosebleeds sore throat
- dentures ear pain history of head injury postnasal drip tinnitus (ringing in ears)
- difficulty swallowing fainting hoarseness rhinorrhea (runny nose) TMJ problems
- discharge frequent sore throats loss of sense of smell sinus infections
- dizziness headaches nasal congestion snoring

Respiration: I DENY having or have had any of the symptoms or problems listed below.

- asthma coughing up blood sputum production
- cough shortness of breath wheezing

Cardiovascular: I DENY having or have had any of the symptoms or problems listed below.

- angina (chest pain or discomfort) high blood pressure shortness of breath (with exertion or exercise)
- chest pain low blood pressure swelling of legs
- claudication (leg pain/ache) orthopnea (difficulty breathing lying down) ulcers
- heart murmur palpitations varicose veins
- heart problems paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: I DENY having or have had any of the symptoms or problems listed below.

- abdominal pain diarrhea indigestion abnormal stool caliber vomiting blood
- belching difficulty swallowing jaundice abnormal stool color
- black - tarry stools heartburn nausea abnormal stool consistency
- constipation hemorrhoids rectal bleeding vomiting

Female: I DENY having or have had any of the symptoms or problems listed below.

- birth control cramps irregular menstruation
- breast lumps/pain frequent urination pregnancy
- burning urination hormone therapy urine retention

Male: I DENY having or have had any of the symptoms or problems listed below.

- burning urination frequent urination prostate problems
- erectile dysfunction hesitancy/ dribbling urine retention

Endocrine: I DENY having or have had any of the symptoms or problems listed below.

- cold intolerance excessive hunger goiter unusual hair growth
- diabetes excessive thirst hair loss voice changes
- excessive appetite abnormal frequency of urination heat intolerance

Skin: I DENY having or have had any of the symptoms or problems listed below.

- changes in nail texture hair loss itching skin lesions / ulcers
- changes in skin color hives paresthesias varicosities
- hair growth history of skin disorders rash

Nervous System: I DENY having or have had any of the symptoms or problems listed below.

- dizziness limb weakness numbness slurred speech tremor
- facial weakness loss of consciousness seizures stress unsteadiness of gait/ loss of balance
- headache loss of memory sleep disturbance strokes

Psychologic: I DENY having or have had any of the symptoms or problems listed below.

- depression behavioral change convulsions memory loss
- anxiety bi-polar disorder insomnia
- loss or change in appetite confusion mood change

Allergy: I DENY having or have had any of the symptoms or problems listed below.

- anaphalaxis itching chronic nasal congestion sneezing
- food intolerance acute nasal congestion rash

Hematologic: I DENY having or have had any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
- bleeding blood transfusion fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all conditions.

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hayfever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental sugery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Females ONLY: Ob/Gyn Mark all that apply below.

- | | | |
|---------------------------|--|--|
| I... | <input type="checkbox"/> am currently pregnant | <input type="checkbox"/> am NOT currently pregnant |
| Menstrual History. | | |
| My menses... | <input type="checkbox"/> are regular. | <input type="checkbox"/> are NOT regular. |

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> dairy | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> other: | | | |

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

- | | | | |
|---------------------------------|-------------------|---------------|-------------------------|
| 1. angioedema/rapid swelling | 3. GI disturbance | 5. joint pain | 7. shortness of breath |
| 2. anaphylaxis/life threatening | 4. headache | 6. rash | 8. unspecified reaction |

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

- | | | | | | |
|-------------------|--------------------------------|-----------------------------------|---|---|---|
| Father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| Mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| Brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| Sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Social History: Mark all that apply below.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
 beer liquor wine; quantity of _____ oz./glasses per day week month

Tobacco: Do not use tobacco

Smoke: # ____ per Day; Chew: # ____ cans per Week

My Dietary Intake consists mainly of the following: (mark all that apply)

ACTIVITIES OF DAILY LIVING (ADL's)

Patient Name: _____ Date: _____ Dr: _____

VERY IMPORTANT

Please accurately check the boxes that apply to your activities of daily living.
We want to discover how your problems are affecting your daily activities.

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn–Sit–Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static (long period) Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static (long period) Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Level of Impairment Due to Symptoms (RESTING):

0 1 2 3 4 5 6 7 8 9 10 +
 { MILD } { MODERATE } { SEVERE } { HOSPITAL }

Level of Impairment Due to Symptoms (WITH ACTIVITY):

0 1 2 3 4 5 6 7 8 9 10 +
 { MILD } { MODERATE } { SEVERE } { HOSPITAL }

Patient Signature