Confidential Patient Health Record

Today's Date: 5/23/2008

How did you hear about us? ☐ Family _____ ☒ Friend John Smith ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Title: ☐ Mr. ☐ Ms. ☒ Mrs.

Last: Doe First: Jane Middle: _____

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III

Birth Date: 11/15/1970 Age: _____ Sex: Male / (Female)

Marital Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

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

Cell Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

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

Work Phone: (_____) _____-_____ ext _____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?): Neck Pain

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

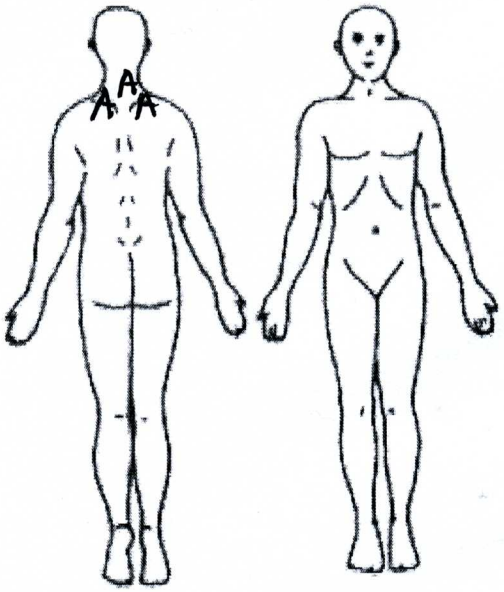
_____

Patient Name: Jane Doe Date: 5/23/08

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? 5 / 17 / 08

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: Painting in House

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

Condition/Pain STARTED on what Date: _____

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.

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 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 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 any of the symptoms or problems listed below.

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

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

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

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

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

Female: ☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

- ☒ birth control
- ☐ breast lumps/pain
- ☐ burning urination
- ☐ cramps
- ☐ frequent urination
- ☐ hormone therapy
- ☐ irregular menstruation
- ☐ pregnancy
- ☐ urine retention
- ☐ vaginal bleeding
- ☐ vaginal discharge

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient Name: Jane Doe Date: 5/23/08

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)** Dr. Marcus Welby
Type of Treatment: Muscle Relaxers **Was the treatment beneficial in resolving condition?** ☐ 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:** _____

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?
Aleeve		Headache	
Birth Control			
Muscle Relaxors		Neck Pain	

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

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

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

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ alzheimers	☐ depression	☐ influenzal pneumonia	☐ scoliosis
☐ anemia	☐ diabetes (insulin dep)	☐ liver disease	☐ seizures
☐ arthritis	☐ diabetes (non insulin)	☐ lung disease	☐ shingles
☐ asthma	☐ eczema	☐ lupus erythema (discoid)	☐ past history of similar symptoms
☐ cancer	☐ emphysema	☐ lupus erythema (systemic)	☐ STD's (unspecified)
☐ cerebral palsy	☐ eye problems	☐ multiple sclerosis	☐ suicide attempt(s)
☐ chicken pox	☐ fibromyalgia	☐ parkinson's disease	☐ thyroid problems
☐ crohn's/colitis	☐ heart disease	☐ unspecified pleural effusion	☐ vertigo
☐ CRPS (RSD)	☐ hepatitis	☐ pneumonia	☐ other:
☐ CVA (stroke)	☐ HIV	☐ psoriasis	

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

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

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☒ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

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

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

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

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific):_____

Personal Health Insurance Carrier: _____ **Health ID Card #:** _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Date of Birth: ____-____-____ **Primary Care Physician:** _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐ No **Date:**____/____/_____**Time:** _____am/pm

Carrier: _____ **Policy #** _____

Carriers Phone #: (_____) _____-_____ **Adjuster:** _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____