

Confidential Patient Health Record

Today's Date: ___ / ___ / ___

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Internet

Personal Information

Title: Mr. Ms. Mrs.
Last: _____ First: _____ Middle: _____
Suffix: Jr Sr II III
Birth Date: ___ / ___ / ___ Age: _____ Sex: Male / Female SSN: _____
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 _____

Patient Name: _____

Date: _____

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.

- | | | | |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> fever | <input type="checkbox"/> weight gain | |

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

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> wear glasses/contacts |

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

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

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

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |

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

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

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

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool caliber | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> cramps | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy | <input type="checkbox"/> urine retention | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention |

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

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

Patient Name: _____

Date: _____

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

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

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

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

Hematologic: I DENY having 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: _____ 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? |
|------------|--------|---------------------|-------------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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 (discoïd) past history of similar symptoms
- cancer emphysema lupus erythema (systemic) STD's (unspecified)

Patient Name: _____

Date: _____

- | | | | |
|--|--|---|---|
| <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 | |

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

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 surgery | <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 | |

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: |

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: _____

Patient Name: _____

Date: _____

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Case: _____ Date: _____ Dr: _____

Chief

Complaint:

Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New → Acute or Chronic
 Recurrence (Acute) Exacerbation (Acute) Chronic

Mechanism of Onset:

Auto: Driver/Passenger Pedestrian (refer to completed auto accident history form)
 Work Related: Fall Falling Object Lifting Overexertion Repetitive Motion Other:

Other – Liability: Slip or Fall Other:

Other – No Liability: Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall

No Injury

Description of Onset of Complaint: _____

Current Symptoms: Pain Numbness Stiffness Weakness

Location: Left / Right / Bilateral

Quality: Burning Diffuse Dull/Aching Localized Radiating Sharp Shooting
 Stabbing Throbbing Tightness Tingling Other

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9
10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9
10

Duration: Started: _____

Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____

Worsened: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: *Worse:* Morning Afternoon Night with Activity; Constant Intermittent

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swing
 Localized Tingling Nausea Ringing in Ears Sleep Disturbance Stiffness

Headaches: Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus

Quality: Dull Sharp Throbbing Stabbing Other

Types: Hat Band Cluster Migraine Tension

Patient Name: _____

Date: _____

Other: _____ (frequency/duration/time of day)

Other Assoc Signs and Symptoms:

- aches
- ecchymosis
- muscle spasm
- panic
- swelling
- burning
- chronic fatigue
- muscle weakness
- pins & needles
- tingling
- cold limb(s)
- fever
- nausea
- rhinorrhea (runny nose)
- vomiting
- difficulty walking
- heartburn
- numbness
- shortness of breath
- dizziness
- joint stiffness
- pale bluish skin
- sweating

Modifying Factors:

- Symptoms Better With: nothing helps activity applying cold
- massage rest Rx meds
- stretching applying heat other

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: 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
- Sexual Activities: 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 Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static 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

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description _____ of _____ Work: _____

- Job Classification:** Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)
- Lifting Frequency:** Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)
- Lifting Postures:** with Arms High Near from Knee Off Posture from Torso

Patient Name: _____

Date: _____

Work Activity Postures: (hrs/day)

- _____ h/d **bending:**
 _____ h/d **climbing:**
 _____ h/d **kneeling:**
 _____ h/d **pulling:**
 _____ h/d **pushing:**
 _____ h/d **reaching:**
 _____ h/d **sitting:**
 _____ h/d **standing:**
 _____ h/d **twisting:**
 _____ h/d **walking:**

Repetitive Activities: (hrs/day)

- assembly/fine manipulation: _____ h/d
 computer use/typing: _____ h/d
 grasping: _____ h/d
 hand tool use: _____ h/d
 operation of machinery controls: _____ h/d
 phone use: _____ h/d

Condition's Effect On Job Performance:

- Mild** Painful (Can do)
 Mod Painful (limited ability)
 Mod/Sev Limited Duty
 Sev No Limited Duty
 Sev (can't do limited duty)

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

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