

**Confidential Patient Health Record**

**DATE:** \_\_\_\_\_

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male or Female  
Social Security #: \_\_\_\_\_  
Social Insurance #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Type of Work: \_\_\_\_\_ Name and Ages of Children: \_\_\_\_\_  
Referred To This Office By: \_\_\_\_\_  
Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who is Responsible for Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid

Personal Health Insurance (Name) \_\_\_\_\_ Health Card # \_\_\_\_\_  
Insured Person's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Unwanted Health Condition: \_\_\_\_\_

Other Doctors Seen for this Conditions: YES NO Who? \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When did this Conditions Begin? \_\_\_\_\_ Has this Condition Occurred Before? YES NO

Is Conditions: 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  
Insulin Other: \_\_\_\_\_

Do You Wear A Shoe Liff? YES NO

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

**PAST HEALTH HISTORY**

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 Last 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 care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- |                 |               |                  |             |
|-----------------|---------------|------------------|-------------|
| Pneumonia       | Mumps         | Influenza        | INTAKE      |
| Rheumatic Fever | Small Pox     | Pleurisy         | Coffee      |
| Polio           | Chicken Pox   | Arthritis        | Tea         |
| Tuberculosis    | Diabetes      | Epilepsy         | Alcohol     |
| Whooping Cough  | Cancer        | Mental Disorders | Cigarettes  |
| Anemia          | Heart Disease | Lumbago          | White Sugar |
| Measles         | Thyroid       | Eczema           |             |

Have you been tested HIV positive? YES No

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

**MUSCULO-SKELETAL CODE**

- |                                |                          |
|--------------------------------|--------------------------|
| Low Back Pain                  | Gas/Bloating After Meals |
| Pain Between Shoulders         | Heartburn                |
| Neck Pain                      | Black/Bloody Stool       |
| Arm Pain                       | Colitis                  |
| Joint Pain/Stiffness           |                          |
| Walking Problems               |                          |
| Difficult Chewing/Clicking Jaw |                          |
| General Stiffness              |                          |

**GENTO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**NERVOUS SYSTEM CODE**

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

**C-V-R CODE**

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

**GENERAL CODE**

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

**EENT CODE**

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

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**MALE/FEMALE CODE**

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

\_\_\_\_\_

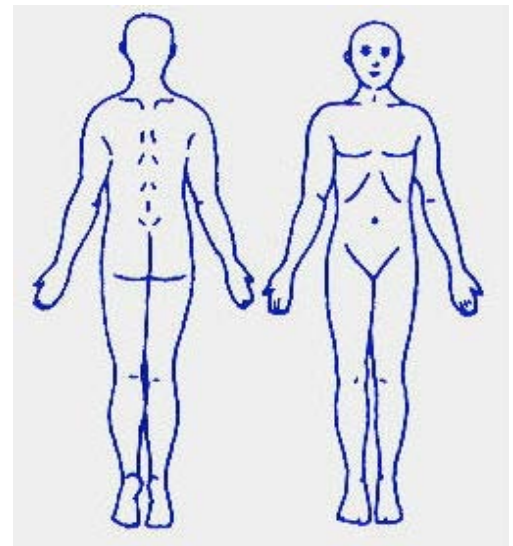
\_\_\_\_\_

\_\_\_\_\_

**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**

ANALYSIS:

DIAGNOSIS:

Patient Accepted: YES NO Referred

\_\_\_\_\_  
Doctor's Signature

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come 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 you 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 care 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 Length of 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 upon 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 or she deems appropriate. 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.

**Patient's Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Consent to treat a Minor** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Guardian or Spouse's  
Signature of Authorizing Care:** \_\_\_\_\_

**Date:** \_\_\_\_\_