Confidential Patient Health Record

***Today's Date:*___/____/_______**

Who can we thank for referring you?

Personal Information

Last Name:_________________________________ First Name:______________________________ Middle Initial:______

Birth Date: _____ /_____/_______ Age:_________ ☐ Male ☐ Female

Social Security #: _________-_________-______________Driver's License #: ______________________ State: ______

Address: ____Apt # ________

City:___________________________State:________Zip:______________ Home Phone: (______)_______-____________

Work Phone: (_______)_______-____________ Cell Phone: (_______)_______-______________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Spouse's Name: _________________________________

Emergency Contact

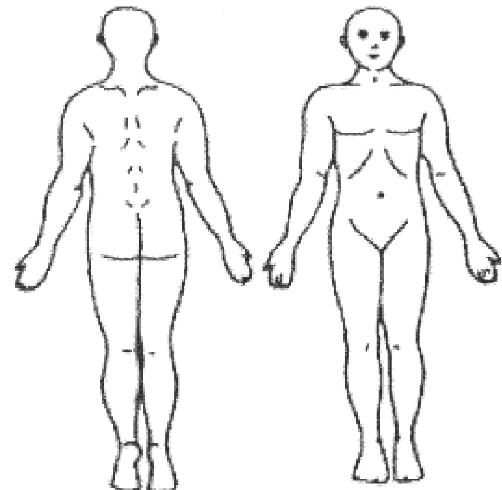
Name: _____________________________________ Relationship:_____________ Phone: (_______)________-____________

Address: ____

Current Health Condition

What is your chief complaint:_______________________________
____

Mark the diagram below to indicate the areas of your symptoms.



Body Area(s) Involved: ☐ Neck ☐ Spine, Ribs, Pelvis ☐ Arm ☐ Leg

Is this condition: ☐ New ☐ Worsening of a old condition ☐ Chronic

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip/Fall ☐ Lifting ☐ Overexertion ☐ Repetitive Motion

☐ Slept Wrong ☐ Unknown Cause ☐ Other:________________________

Current Symptoms: **☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness**

Location: **☐Left Side ☐Right Side ☐Both Sides ☐Upper ☐Mid ☐Lower**

☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp

☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other

Circle Your Level of Impairment Due to Symptoms (While Resting):

0 pain free **1** very slight/rarely **2** slight/rarely **3** slight/occasional **4** slight/frequent **5** moderate/occasional

6 moderate/frequent **7** severe/occasional **8** severe/frequent **9** very severe/occasional **10** very severe/ constant

Circle Your Level of Impairment Due to Symptoms (With Activity):

0 pain free **1** very slight/rarely **2** slight/rarely **3** slight/occasional **4** slight/frequent **5** moderate/occasional

6 moderate/frequent **7** severe/occasional **8** severe/frequent **9** very severe/occasional **10** very severe/ constant

Duration: **Date symptoms began:_________________________ Date worsened:_________________________**

Date last experienced symptoms: _________________________

Symptoms worse: **☐Morning ☐Afternoon ☐Night ☐With Activity** *Symptoms are:* **☐Constant ☐Intermittent**

Symptoms better in: ☐ **Warm Temp** ☐ **Cold Temp** *Worse in:* ☐ **Warm Temp** ☐ **Cold Temp** ☐ **Damp Weather**

*If your primary complaint is in your **neck**, check any associated symptoms you might be experiencing:*

☐ **Radiating Pain to ________** ☐ **Weakness in ________** ☐ **Blurred Vision** ☐ **Depression**

☐ **Dizziness** ☐ **Irritability/Mood Swings** ☐ **Tingling** ☐ **Nausea** ☐ **Ringing in the Ears** ☐ **Sleep Disturbance**

☐ **Headaches:** *Location* ☐ **Occipital** ☐ **Frontal** ☐ **Left Temporal** ☐ **Right Temporal** ☐ **Parietal** ☐ **Sinus** ☐ **Hat Band**

Quality of headaches: ☐ **Dull** ☐ **Sharp** ☐ **Throbbing** ☐ **Stabbing** ☐ **Aura** ☐ **No Aura**

☐ **Cluster** ☐ **Migraine** ☐ **Tension** ☐ **Frequency/Duration/Time of Day):____________________________________**

*If your primary complaint is in your **spine, ribs or pelvis**, check any associated symptoms you are experiencing:*

☐ **Aches** ☐ **Burning** ☐ **Cold Limbs** ☐ **Difficulty Walking** ☐ **Dizziness** ☐ **Bruising** ☐ **Chronic Fatigue**

☐ **Fever** ☐ **Heartburn** ☐ **Joint Stiffness** ☐ **Muscle Spasms** ☐ **Muscle Weakness** ☐ **Nausea** ☐ **Numbness**

☐ **Pale/Bluish Skin** ☐ **Panic Attacks** ☐ **Pins & Needles** ☐ **Runny Nose** ☐ **Shortness of Breath** ☐ **Sweating**

☐ **Swelling** ☐ **Tingling** ☐ **Vomiting**

Symptoms Better With: ☐ **Activity** ☐ **Bending** ☐ **Applying Cold** ☐ **Applying Heat** ☐ **Massage** ☐ **Movement**

☐ **OTC Meds** ☐ **Prescription Meds** ☐ **Rest** ☐ **Sitting** ☐ **Stretching** ☐ **Standing** ☐ **Twisting** ☐ **Walking** ☐ **Nothing**

REVIEW OF SYSTEMS – Please check any symptoms that you have.

Constitutional: ☐ **I don't have any of the symptoms or problems listed below.**

☐ **chills** ☐ **daytime drowsiness** ☐ **fatigue** ☐ **fever** ☐ **night sweats**
☐ **weight gain** ☐ **weight loss** ☐ **other:**

Eyes/Vision: ☐ **I don't have any of the symptoms or problems listed below.**

☐ **blindness** ☐ **blurred vision** ☐ **cataracts** ☐ **change in vision** ☐ **double vision**
☐ **eye pain** ☐ **field cuts** ☐ **glaucoma** ☐ **itching** ☐ **photophobia**
☐ **tearing** ☐ **glasses** ☐ **contact lenses** ☐ **other:**

Ears, Nose and Throat: ☐ **I don't have any of the symptoms or problems listed below.**

☐ **bleeding** ☐ **dentures** ☐ **difficulty swallowing** ☐ **discharge** ☐ **dizziness**
☐ **ear drainage** ☐ **ear pain** ☐ **fainting** ☐ **frequent sore throat** ☐ **headaches**
☐ **hearing loss** ☐ **past head injury** ☐ **hoarseness** ☐ **loss of sense of smell** ☐ **nasal congestion**
☐ **nosebleeds** ☐ **postnasal drip** ☐ **runny nose** ☐ **sinus infections** ☐ **snoring**
☐ **sore throat** ☐ **ringing in ears** ☐ **TMJ problems** ☐ **other:**

Respiratory: ☐ **I don't have any of the symptoms or problems listed below.**

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

Cardiovascular: ☐ **I don't have 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**
☐ **varicose veins** ☐ **other:**

Gastrointestinal: ☐ **I don't have 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 ☐ ulcers
☐ other:

Female: ☐ **I don't have any of the symptoms or problems listed below nor do I use items listed.**

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

Male: ☐ **I don't have any of the symptoms or problems listed below.**

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

Endocrine: ☐ **I don't have any of the symptoms or problems listed below.**

☐ cold intolerance ☐ diabetes ☐ excessive appetite ☐ excessive hunger ☐ excessive thirst
☐ abnormal frequent urination ☐ goiter ☐ hair loss ☐ heat intolerance ☐ unusual hair growth
☐ voice changes ☐ other:

Skin: ☐ **I don't have 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 ☐ paresthesia/ numbness ☐ rash ☐ skin lesions / ulcers
☐ varicosities ☐ other:

Nervous System: ☐ **I don't have 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 ☐ unsteady gait ☐ loss of balance ☐ other:

Psychological: ☐ **I don't have any of the symptoms or problems listed below.**

☐ inability to experience pleasure ☐ anxiety ☐ loss or change in appetite ☐ behavioral change ☐ bi-polar disorder
☐ confusion ☐ convulsions ☐ depression ☐ memory loss
☐ mood change ☐ other:

Allergies: ☐ **I don't have any of the symptoms or problems listed below.**

☐ anaphalaxis/ allergic reaction ☐ food intolerance ☐ itching ☐ nasal congestion ☐ rash
☐ sneezing ☐ other:

Hematological : ☐ **I don't have any of the symptoms or problems listed below.**

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

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

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No If yes, Name?____________________________________

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

Explain: ____

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?

Do you wear any of the following? ☐ **Heel Lifts** ☐ **Innersoles** ☐ **Arch Supports** ☐ **Orthotics** ☐ **Other__________________**

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? ____**

Childhood Illness (es): **LIST all childhood illnesses. CIRCLE any that are CURRENT conditions.**

____

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

____

____

Surgery (ies): **LIST All Surgical Procedures And Dates Performed.**

____

____

Females ONLY: **Mark all that apply.**

I AM: ☐ **currently pregnant** ☐ **NOT pregnant** ☐ **unsure**

Past Pregnancy History: ☐ **C-section** ☐ **vaginal delivery** ☐ **miscarriage**

Injury (ies): **Mark All Injuries and List Date of Injury.**

☐ **back injury**	☐ **broken bones**	☐ **fall (severe)**	☐ **fracture**
☐ **disability (ies)**	☐ **head injury**	☐ **loss of consciousness**	☐ **joint injury**
☐ **laceration (severe)**	☐ **motor vehicle accident**	☐ **soft tissue injury**	☐ **other:**

Social History: **Mark all that apply.**

Tobacco: ☐ **None** ☐ **Smoke** ☐ **Smoke or Chew #______ cigarettes/cigars/pipe/cans per** ☐ **Day** ☐ **Week** ☐ **Month**

☐ **Live with a smoker** ☐ **Quit smoking in __________ after smoking for __________ years**

Alcohol: ☐ **None** ☐ **Drink socially Consume:** ☐ **Beer** ☐ **Liquor** ☐ **Wine #_______ounces** ☐ **day** ☐ **week** ☐ **month**

Drug Use: ☐ **Never** ☐ **Rare drug use** ☐ **Occasional drug use** ☐ **Frequent drug use** ☐ **Last used:_____________**

Diet: ☐ **No Specific Diet** ☐ **List specific diet ____**

Education: **List highest grade or degree completed ____**

Employment Information

Occupation: _______________________________ Employer:_____________________________ Work(# hours/day): _______

Job Classification: ☐ **Sedentary (<5lbs)** ☐ **Light (5-20lbs)** ☐ **Moderate (20-50lbs)** ☐ **Heavy (>50 lbs)**

Lifting Frequency: ☐ **Constant (66-100%/day)** ☐ **Frequent (33-65%/day)** ☐ **Occasional (0-32%/day)**

Lifting Postures: ☐ **Torso** ☐ **Knee** ☐ **Arm** ☐ **Shoulder** ☐ **High Near** ☐ **Off Posture**

Work Activity Postures: (# hours/day) Sitting:___ Standing:___ Walking:___ Climbing:___ Pushing:___ Pulling:___

Kneeling:___ Reaching:___ Twisting:___

Repetitive Activities:(# hours/day) Computer:___ Phone:___ Machinery:___ Hand Tools: ___ Assembly:___

Grasping:___

Condition's Effect On Job Performance: ☐ **No effect** ☐ **Mildly Painful/can do** ☐ **Moderately Painful/limits ability**

☐ **Moderately Severe/limited duty** ☐ **Severe/no limited duty** ☐ **Severe/can't do limited duty**

Daily Activities: Effects of Current Condition on Performance:

Bending:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Care infirm family:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Carrying groceries:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Change positions/sit-stand:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Climb Stairs:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Driving:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Extended computer use:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Feeding:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Household Chores:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Kneeling:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Lifting:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Lifting Children:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Pet Care:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Reading/concentration:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Self care-Bathing:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Self care-Dressing:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Self care-Shaving:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Sexual Activities:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Sleep:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Prolonged Sitting:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Prolonged Standing:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Walking:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
Yard work:	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**

Recreational Activities/Hobbies: Effects of Current Condition on Performance:

____________________	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
____________________	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**
____________________	☐ **No Effect**	☐ **Mildly painful/can do**	☐ **Moderately painful/limited**	☐ **Severe/unable to do**