Confidential Patient Health Record

Patient Information:

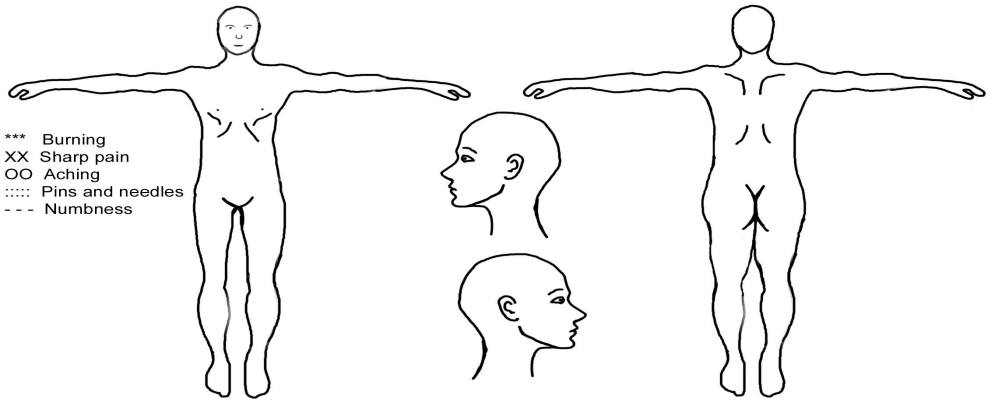
Name:_____ Date:_____ Soc. Sec. #: _____-____-_____
Address:_____ Home Phone:_____ Cell Phone: _____
City: _____ Work Phone:_____ Spouse's name:_____
State/Zip:_____ Birth Date: ____ /____/_____ Employer: _____
Would you like to receive educational & promotional info from us by e-mail? Email:_____
Name/Age of Children at home: _____ Occupation: _____
Insured's Name: _____ Insured's Birth Date: _____
Insured's Address: _____ Insured's Soc. Sec. #: _____
Emergency Contact Information: _____
Name Relationship Phone #

Who referred you to our office? Another patient or doctor's office? _____
Name: _____

History of Present Injury/Illness

Please be as accurate as possible with the following information. Mark any areas of discomfort with the appropriate symbols. If there is more than one area of discomfort, **please rate each area on a scale of 1-10 (10 being the worst) and write the rating down beside the affected area.**

When did the problem begin? _____ Please explain what happened: _____
_____



Pain Type: Active / Minimal / Moderate / Severe / Shooting / Radiating / Numbness / Deep
Superficial / Sharp / Burning / Dull / Achy / Stinging / Throbbing / Piercing / Stabbing
Other: _____

Location: Left / Right / Both **Pain Scale**: 0 1 2 3 4 5 6 7 8 9 10
w/ Activity At Rest w/ Work Activity w/o Work Activity

Frequency of Pain: ____% of waking time Sporadic / Intermittent / Constant / Occasionally
Persistent / Constant Varies / None

Aggravating Factors: Bending / Coughing / Driving / Exercise / Household Chores / Laying Supine
Lifting / Looking Down / Looking Up / Movement / Reaching / Resting / Scooping
Sitting / Sleeping / Sneezing / Stair Stepping / Standing / Stooping / Straining
Twisting / Typing / Walking

Relieving Factors: Adjustment Provided / Analgesic Topical Applied / Back Lying Knees Up /
Exercises-Stretching / Heat / Ibuprofen Taken / Ice / Laying Down /
Leaning Against a Support / Medication / Movement Occurs / No Movement Occurs
Rest / Sitting / Standing

Pain Radiates To: Cervical / Thoracic / Upper Extremities / Lumbar / Lower Extremities
Pain Worse In: Morning / Afternoon / Evening / All Day
Additional Information on Pain: _____

System Review Questions

Have you had any problems with the following areas? Mark Y for yes, and N for no

___ Eyes?	___ Urinary?	___ Internal Organs?	___ Blood?
___ Heart?	___ Muscles?	___ Nerves?	___ Allergies?
___ Lungs?	___ Ears/nose/throat?	___ Skin?	___ Intestines?
___ Psychological?	___ Other? _____		

Please describe:_____

Past Medical History

How many times have you had the condition for which you are seeing us today? ___ 0-3 times __ 4 +

Yes No

_____ _____ Do you suffer from any condition other than that for which you are now consulting us? (Diabetes, High Blood Pressure, etc) _____

_____ _____ Have you ever seen a chiropractor before?
Name_____ Date_____ Condition _____ Results_____
Name_____ Date_____ Condition _____ Results_____

_____ _____ Have you seen a doctor for this condition?
Name_____ Date_____ Condition _____ Results_____
Name_____ Date_____ Condition _____ Results_____

_____ _____ Are you allergic to anything? What? _____

_____ _____ Do you now take prescription drugs, over the counter drugs, vitamins or supplements?
Drug_____ Reason _____ Frequency/Dosage?_____
Drug_____ Reason _____ Frequency/Dosage?_____
Drug_____ Reason _____ Frequency/Dosage?_____

_____ _____ Have you had any major illnesses, injuries, falls, hospitalizations, auto accidents or surgeries? What and when? _____
_____
_____

_____ _____ Have you had X-Rays? When? _____ Where? _____

Social Health History

____ Male _____ Female ____ Single ____ Married ____ Other ____Student ___FT/___PT

Occupation:_____ Employer: _____

Work Hours per week: _____ Hobbies/Rec. Activities: _____

Yes No

____ _____ Do you commute to work? How far? _____

____ _____ Do you exercise? _____ times per _____

____ _____ Are you a smoker? _____ packs per day

____ _____ Do you consume caffeine? How much per day? _____

____ _____ Do you consume alcohol? Glasses per day/week? _____

Family Health History

Health status of family members. (If deceased, from what?)

Mother _____
Father _____
Sisters _____
Brothers _____
Children _____

Additional Comments

_____
_____
_____

My signature is an acknowledgment that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as s/he deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. I also give permission for my case to be used for research purposes, if so approved.

Patient/Guardian Signature: _____Date:_____

D.C./C.A. _____Date:_____