

PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____ Zip _____
Home phone _____ Birth date _____
Cell Phone _____ Work Phone _____
Email _____
Occupation _____
Employer _____
Work address _____
Marital Status _____
Do you have any children? Ages _____
Social Security # _____
Health Insurance _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

When did this condition begin? _____
What makes it better? _____
What makes it worse? _____
Does the pain
 Stay in one spot Radiate to other areas
Type of pain
 Sharp with motion Deep burning
 Dull ache Throbbing
Has this condition
 Gotten worse Stayed constant Comes and goes
Does this condition interfere with
 Work Sleep Daily routine Other activities
Please explain _____
Has this condition occurred before? Yes No
Please explain _____
Have you seen other doctors for this condition?
 Yes No
Doctor's Name(s) _____
Type of treatment _____
Results _____
Any other recent health concerns? _____

ABOUT YOUR SIGNIFICANT OTHER

Name _____
Employer _____
Work phone _____
Occupation _____

MEDICATIONS I NOW TAKE

- Nerve pills Stimulants
- Blood thinners Tranquilizers
- Muscle relaxer Insulin
- Blood pressure medicine
- Pain killers (including aspirin)
- None
- _____
- _____
- _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____
Have you been adjusted by a Chiropractor before? Yes No
Reason for those visits? _____
Doctor's name _____
Approximate date of last visit _____
Has any adult in your family seen a Chiropractor? Yes No
Has any child in your family seen a Chiropractor? Yes No
Were you aware that
• Doctors of Chiropractic work with the nervous system? Yes No
• The nervous system controls all bodily functions and systems? Yes No

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall analysis, care plan and the possibility of being accepted for care.

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|---|--|---|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Diabetes | For women: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Kidney problems | Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hepatitis | Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cancer | Do you experience painful periods? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Numbness in Arms/legs/hands | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemotherapy | Do you have irregular cycles? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain in Arms/legs/hands | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Psychiatric problems | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Thyroid problems | |
| | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Lower back problems | |
| | <input type="checkbox"/> _____ | <input type="checkbox"/> Ulcers/Colitis | |
| | | <input type="checkbox"/> _____ | |

CURRENT LIFESTYLE

<p><u>Physical Dimension</u></p> <p>Do you exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you stretching daily? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you interested in exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you pay attention to posture? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><u>Psychological Dimension</u></p> <p>Do you feel "stressed out" regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you practice relaxation/meditation techniques daily? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you handle stress in a positive way? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Is lack of time and/or energy during the day a source of stress for you? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><u>Bio-Chemical Dimension</u></p> <p>Do you eat prepared, processed or fast foods? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you consume caffeinated, carbonated, or drinks high in sugar daily? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you take nutritional supplements? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you satisfied with your current level of health? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Is your current level of health limiting you from doing things you enjoy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Would you like help improving your current lifestyle? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
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GOALS FOR MY HEALTH

Please mark on the continuum:

1. Where you feel you are now.

2. Where you want to be.



I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____