PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name____

Address____

City______________________________State_______________

Zip __________________Home phone ___________________

Birth date _______________ Cell Phone___________________

Age ___________ Gender _______ Number of children ______

Employer _______________________________________

Work address ___________________________________

Work phone ____________________________________

Type of work ___________________________________

Marital Status ___________________________________

Social Security # ________________________________

E-mail address __________________________________

Payment method ❑ Cash ❑ Check ❑ Credit card

REASON FOR THIS VISIT

Describe the purpose of this visit _______________________

____

Is the purpose of this appointment related to

❑ Job ❑ Sports ❑ Auto ❑ Fall

❑ Home Injury ❑ Chronic Discomfort ❑ Other

Please explain _______________________________________

If job related, have you made a report of you accident to your employer? ❑ Yes ❑ No

When did this condition begin? _________________________

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 ____

ABOUT THE PARTNER

Name ___________________________________

Employer ________________________________

Work phone ______________________________

Type of work _____________________________

HEALTH HABITS

	No	Yes
Do you smoke?	❑	❑
Do you drink alcohol?	❑	❑
Do you drink coffee, tea or soda?	❑	❑
Do you exercise regularly?	❑	❑

Do you wear:

❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _______________________________

Have you seen or heard about us in/on: ___Paper ___Clinic Sign ___YP

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

AWARENESS OF CHIROPRACTIC PRINCIPLES

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
- Chiropractic is the largest natural healing profession in the world? ❑ Yes ❑ No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❑ Yes ❑ No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your 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** – Symptomatic relief of pain or discomfort
- ❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms
- ❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- ❑ I want the Doctor to select the type of care appropriate for my condition.

____________________________________ ________________________

Patient's signature Date

MEDICATIONS I NOW TAKE

- ❑ Cholestral medication
- ❑ Stimulants
- ❑ Blood thinners
- ❑ Tranquilizers
- ❑ Pain killers (including aspirin)
- ❑ Muscle relaxers
- ❑ _______________________
- ❑ Insulin
- ❑ _______________________

Vitamins & Supplements I now take:__________________

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____

____

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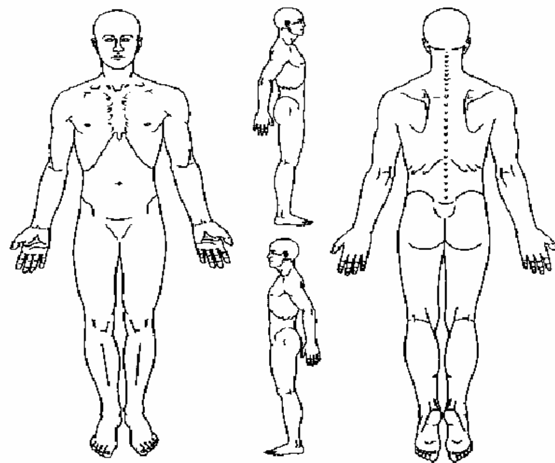

N=NUMBNESS **P**=PAIN **T**=TINGLING **ST**=STIFFNESS

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 diagnosis, care plan and the possibility of being accepted for care.

- ❑ Severe or frequent headaches
- ❑ Sinus problems
- ❑ Dizziness
- ❑ Loss of sleep
- ❑ Pain between shoulders
- ❑ Frequent neck pain
- ❑ Numbness in Arms/legs/hands
- ❑ Pain in Arms/legs/hands
- ❑ Lower back problems
- ❑ Digestive problems
- ❑ Heart surgery/ Pacemaker
- ❑Heart attack/stroke
- ❑ Heart murmur
- ❑ Congenital heart defect
- ❑ High/Low blood pressure
- ❑ Difficulty breathing
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Alcohol/drug abuse
- ❑ Venereal disease
- ❑ HIV/AIDS
- ❑ Ulcers/Colitis
- ❑ Arthritis
- ❑ Diabetes
- ❑ Shingles
- ❑ Kidney problems
- ❑ Hepatitis
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Rheumatic fever
- ❑ Psychiatric problems
- ❑ Thyroid problems
- ❑ Surgeries
- ❑ _________________
- ❑ _________________

For women:

Question		
Are you pregnant?	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No
Are you taking birth control?	❑ Yes	❑ No
Do you experience painful periods?	❑ Yes	❑ No
Do you have irregular cycles?	❑ Yes	❑ No
Do you have breast implants?	❑ Yes	❑ No

It is understood and agreed that the payments to the Doctor for X-rays is for examination of x-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office. 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:__________________