Confidential Patient Health Record Date:______________________

PERSONAL HISTORY

Name:____Address:____

City:____ State: _________Zip____________________

Home Phone: ____________________________Cell: ____________________________________ Age :_____ Sex: _____M _____F

Birth Date: _______________ ___Single ___Widowed ___Divorced ___Separated ___Married ___Domestic Partner ___Significant Other

E-mail: ____ Do You Use FaceBook: _____Y _____N

Employer:____ Type of Work:____

Name of Spouse:__________________________________ Spouse's Employer :____

Type of Work:_____________________________ Name & Ages of Children____

Who May We Thank For Referring You: ____

Who Is Responsible For Your Bill, You **and** __________spouse _________Worker's Comp. ________Auto Ins. _______Health Insurance

Personal Health Insurance (Name):______________________________**Health Card#**______________________________________

Insured Person's Name: ____**Date of Birth:**______________________________

Name **& Number** Emergency Contact:____Relationship:________________________

CURRENT HEALTH CONDITION – Today's Complaint?

Today's Complaint:____

Other Doctors Seen For This Condition ____Yes ____No Who?____

Type Of Treatment:____________________________________ Results:____

When Did This Condition begin?____________________ Has This Occurred Before? ____Yes ____No If So, When? _______________

Is This: ______Job Related ______ Auto Accident ______Home Injury ______Fall _____Other:_________________________________

Have You Made A Report of Your Accident To Your Employer: ______ Yes______ No If So, When? __________________________

Drugs You Now Take: _______Nerve Pills _____ Pain Killers ______Muscle Relaxers _____ Blood Pressure _____ Insulin _____BCP

Other:____

Do You Suffer From **Any Condition** Other Than That Which You Are Now Consulting Us?
____

PAST HEALTH HISTORY

Please Check and Describe: Do not leave blank. This must be completed before seeing doctor. If nothing, put N/A.

Major Surgeries/Operations: _______ Appendectomy ______Gall Bladder ______Hernia ______ Back Surgery ______Broken Bones

Other:____

Major Accident or Falls:____________________________________ Minor Car Accidents: ____________________________________

Hospitalization (Other Than Above):____

Previous Chiropractic Care: ______None _____ Yes: Doctor's Name, Year of Last Visit:_____________________________________

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully and completely as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

__Pneumonia
__Rheumatic Fever
__Polio
__Tuberculosis
__Whooping Cough
__Anemia
__Measles

__Mumps
__Small Pox
__Chicken Pox
__Diabetes
__Cancer
__Heart Disease
__Thyroid

__Influenza
__Pleurisy
__Arthritis
__Epilepsy
__Mental Disorders
__Lumbago
__Eczema

INTAKE
__coffee
__Tea
__Alcohol
__Cigarettes
__White Sugar

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

MUSCULO-SKELETAL CODE
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Arm pain
__Pain/Stiffness in Joint

__Walking Problems
__Difficult Chewing/Clicking Jaw
__General Stiffness

__Gas/Bloating After Meals
__Heartburn
__Black/Bloody Stool
__Colitis

FEMALES ONLY:
When Was your last period?_______
Are you pregnant?
___yes ___No

GENITO-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

GENERAL CODE
__Fatigue
__Allergies
__Loss of Sleep
__Fever
__Headaches

C-V-R CODE
__Chest Pain
__Short Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems/Congestion
__Varicose Veins
__Ankle Swelling
__Stroke

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Aches
__Hearing Difficulty
__Stuffed Nose

FAMILY HISTORY
__Mother __FATHER
__Brother __Sister
__Spouse __Child

MALE/FEMALE CODE
__Menstrual Irregularity
__Menstrual Cramps
__Vaginal Pain/Infection
__Breast Pain/Lumps
__Prostate/Sexual Dysfunction
__Other Problems
____
____
____

GASTRO-INTESTINAL CODE
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Gall Bladder Problems
__Weight Trouble
__Abdominal Cramps

DO NOT WRITE BELOW THIS LINE

DIAGNOSIS: _______ _______ _______ _______ _______ _______

_______________________________________ **Doctor's Signature Date** ________________________

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 your **needs** and **desires** when recommending your treatment program.

Relief Care gets rid of your symptoms or pain, but not the cause. It is the same as drying a floor that is wet from a leak in the roof, but not fixing the roof.

Corrective Care gets rid of the symptoms or pain and the cause of the problem. It is 'fixing' the hole in the roof!

Please check the type of care you desire:

____Relief Care **____Corrective Care** **____Allow Doctor to Decide**

****If you are here for treatment of an accident–related injury, please fill out the Accident Form.****

I understand and agree that health and accident insurance policies are an arrangement between me and an insurance carrier. 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 on receipt of payment. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as she or he deems appropriate. It is understood and agreed that the patient is responsible for all bills incurred at this office.

Patient's Signature ____ Date ___________________

Consent to treat minor (name)____

Parent/Guardian Signature ____Date ___________________