

Confidential Patient Health Record

Date: \_\_\_\_\_ I.D. # \_\_\_\_\_

## PERSONAL HISTORY

Name: \_\_\_\_\_ City: \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_ Sex:  M  F  
Social Security # \_\_\_\_\_ Circle One: Married Single Divorced Widow  
Business Employer: \_\_\_\_\_ Business Address: \_\_\_\_\_  
Business Phone # \_\_\_\_\_ Type Of Work: \_\_\_\_\_  
Number And Ages Of Children: \_\_\_\_\_  
Whom may we thank for referring you to us: \_\_\_\_\_  
Name And Relationship Of Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## CURRENT HEALTH CONDITION

Reason for today's visit:  Emergency  New Injury  Old Injury  Chronic Pain  Wellness Visit  
Describe your pain: \_\_\_\_\_ and/or circle: Dull Sharp Achy Throbbing Shooting  
Are you in pain?  Yes  No Rate your pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense  
Did your injury occur during:  Work  Sports/Play  Auto Accident  Routine Household Activity  
When did this condition/accident occur? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Where did your injury occur? \_\_\_\_\_  
Please explain what happened: \_\_\_\_\_

Is your condition getting worse?  Yes  No  Constant  Comes And Goes  
Is your condition interfering with your:  Work  Sleep  Daily routine? If so, how?  
\_\_\_\_\_

What seems to help alleviate your pain?: (i.e. ice, heat, aspirin) \_\_\_\_\_

What seems to make your pain worse? \_\_\_\_\_

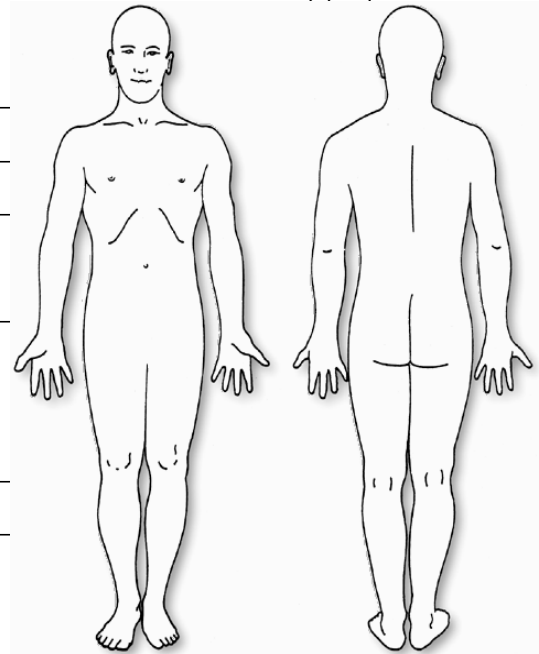
Does it radiate/travel into other parts of your body?  Yes  No Where: \_\_\_\_\_  
\_\_\_\_\_

Has this or something similar happened in the past?  Yes  No

Have you seen anyone else for this condition?  Yes  No Who? \_\_\_\_\_  
\_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

Please mark area(s) of pain:



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Medications you now take:  Nerve Pills     Pain Killers/Muscle Relaxers     Blood Pressure Medicine     Insulin

Other: \_\_\_\_\_

Do you suffer from any condition other than that which you are now consulting us? \_\_\_\_\_

**PAST HEALTH HISTORY**

Please Check And Describe:

Major Surgery/Operations:  Back Surgery     Broken Bones     Bone Fusions     Disc Surgery

Other: \_\_\_\_\_

Major Accidents Or Falls: \_\_\_\_\_

Hospitalizations (Other Than Above): \_\_\_\_\_

Previous Chiropractic Care:  None     Doctor's Name & Approximate Date Of Last Visit: \_\_\_\_\_

Do you have or have you had any of the following diseases, medical conditions or procedures?

Check box if your answer is yes.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Heart Attack/Stroke              | <input type="checkbox"/> Heart Surgery/Pacemaker    | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Mitral Valve Prolapse            | <input type="checkbox"/> Artificial Valves          | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Hepatitis                        | <input type="checkbox"/> Anemia/Diabetes            | <input type="checkbox"/> Shingles           | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Neck Pain                        | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Psychiatric Problems             | <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Ulcers/Colitis                   | <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Sinus Problems     | <input type="checkbox"/> Emphysema               |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Difficulty Breathing       | <input type="checkbox"/> Chemotherapy       | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Artificial Bones/Joints/Implants | <input type="checkbox"/> Lower Back Problems        |   |  |

Do you take any supplements?     Yes     No

Do you exercise regularly?     Yes     No

Do you smoke?     Yes     No

Please list anything that you may be allergic to:  
\_\_\_\_\_

**Dr.'s Notes**

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