



www.chirohealthrockford.com

6769 COURTLAND DRIVE, SUITE 100  
ROCKFORD, MICHIGAN 49341

P: 616.863.9482 F: 616.863.9486

Confidential Patient Health Record

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

PERSONAL HISTORY

Name \_\_\_\_\_ City: \_\_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ 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: \_\_\_\_\_  
Referred To This Office By: \_\_\_\_\_  
Name And Number Of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

CURRENT HEALTH CONDITION

Reason for today's visit:  Emergency  New Injury  Old Injury  Chronic Pain  Wellness Visit

Describe your discomfort: \_\_\_\_\_

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: \_\_\_\_\_

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

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

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 into other parts of your body?  Yes  No Explain: \_\_\_\_\_

Has this or something similar happened in the past?  Yes  No Explain: \_\_\_\_\_

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? \_\_\_\_\_

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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.

- Heart Attack/Stroke
- Heart Surgery/Pacemaker
- Heart Murmur
- Congenital Heart Defect
- Mitral Valve Prolapse
- Artificial Valves
- Alcohol/Drug Abuse
- Venereal Disease
- Hepatitis
- Anemia/Diabetes
- Shingles
- Cancer
- Frequent Neck Pain
- Glaucoma
- Kidney Problems
- High/Low Blood Pressure
- Psychiatric Problems
- Rheumatic Fever
- Tuberculosis
- Severe/frequent Headaches
- Ulcers/Colitis
- Fainting/Seizures/Epilepsy
- Sinus Problems
- Emphysema/Asthma
- Arthritis
- Difficulty Breathing
- Chemotherapy
- Artificial Bones/Joints/Implants
- 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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\_\_\_\_\_

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