CONFIDENTIAL PATIENT HEALTH RECORD

OFFICE USE ONLY

PATIENT NAME:	ACCT #:	EXAM DATE:

AGE:	DOB:	OCCUPATION:

Who referred you to us?

What have you heard about Chiropractic care?

Previous Care under a Chiropractic Physician? ☐ No ☐ Yes Dr. ____

CURRENT HEALTH COMPLAINTS

☐ *Check here if no complaints and skip to next section*

List each major complaint in order of importance to you:	**Rate your pain from 0 (None) to 10 (Extreme)**
A)	
B)	
C)	
D)	

Briefly describe any additional information regarding your condition:

Does bed rest make your symptoms: ☐ Better ☐ Worse ☐ No effect

Does movement make your symptoms: ☐ Better ☐ Worse ☐ No effect

How often do your symptoms bother you?

How long do your symptoms last?

How did this condition appear? ☐ Suddenly on: (date)
☐ Gradually, first noticed: (date)

Cause of condition: ☐ Job related ☐ Auto accident related ☐ Fall ☐ School related ☐ Home injury ☐ Other

What symptoms did you first notice?

Which symptoms appeared later?

Has the same or a similar condition occurred before?
☐ No ☐ Yes (When?)

Have any family members suffered a similar condition? ☐ No ☐ Yes (Who and When?)

Have you seen other Doctors for this condition? ☐ No ☐ Yes (Who and when?)

Type of treatment received:

Results of treatment:

Since the initial onset, have you done anything to make your condition worse? ☐ No ☐ Yes (describe)

PAST HEALTH HISTORY

☐ *Not Remarkable*

Any past auto accidents? ☐ No ☐ Yes Date of accident: ______________ Describe the accident:

Any past work-related accidents? ☐ No ☐ Yes Date of accident: ______________ Describe the accident:

Do you suffer from any conditions other than those symptoms listed above? ☐ No ☐ Yes (describe)

Are you currently taking or using:

- ☐ Insulin
- ☐ Cortisone
- ☐ Nerve Pills
- ☐ Blood pressure medicine
- ☐ Antidepressants
- ☐ Pain killer/muscle relaxants
- ☐ Asprin (how often? _________)
- ☐ Heel lifts: L or R (circle one)
- ☐ Orthotics: custom-made or generic? (circle one)
- ☐ Vitamins/Supplements
- ☐ Other

Any known side-effects or reactions to the above? ☐ No ☐ Yes (describe)

Date of major surgeries:

- ☐ Gall Bladder (   )
- ☐ Hysterectomy (   )
- ☐ Appendectomy (   )
- ☐ Broken bones or fractures (   )
- ☐ Tonsillectomy (   )
- ☐ Back Surgery (   )
- ☐ Hernia (   )
- ☐ Other: ______________ (   )
- ☐ None

PATIENT NAME: **EXAM DATE:**

ACCT #:

Hospitalization? (Other than above): ☐ No ☐ Yes (describe)

Other major accidents, traumas or falls? ☐ No ☐ Yes Date of major accident: ______________________ Describe the accident:

Doctor's name and date of last physical exam?

ACCIDENT & INJURY INFORMATION ONLY ☐ *Not Applicable*

Date of injury: _______________ Please describe the accident:

Please describe the position of your head and body at the time of impact:

Did you have any warning before the impact? ☐ No ☐ Yes

As a result of the accident, were you: ☐ Rendered unconscious ☐ Shaken but could function ☐ Vague about what happened ☐ Dazed
☐ Able to get up/out of car and walk unassisted
☐ Unable to move certain body parts (list parts and why)
☐ Bruised or bleeding (describe injuries)

Were you seen by Emergency Medical Staff at the scene? ☐ No ☐ Yes

Did you visit a hospital ER? ☐ No ☐ Yes (where?)

What areas were checked/treated at that ER?

Have you made any follow-up visits for your injuries? ☐ No ☐ Yes (with whom?)

Have x-rays been taken? ☐ No ☐ Yes (by who?/which body parts?)

Have you previously experienced any of these symptoms before the accident? ☐ No ☐ Yes (which ones? What caused them?)

Did your insurance company give you any information about your condition or treatment that you feel we should know? ☐ No ☐ Yes (explain)

FOR AUTO RELATED ACCIDENTS ONLY:

I was:				
	☐ Owner of the vehicle	☐ Pedestrian	☐ Wearing a seat/lap belt	☐ In a two-car accident
	☐ Driver	☐ In the front seat	☐ Wearing a shoulder harness	☐ Involved with an uninsured driver/vehicle
	☐ Passenger	☐ In the back seat	☐ In a single car accident	

Does your car have headrests? ☐ No ☐ Yes

Describe the damage to the car and its estimated value:

TYPE OF CARE

People go to a Chiropractor for a variety of reasons. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you desire so that we may be guided by your wishes whenever possible:

☐ Comprehensive Care – to bring your body to the highest state of possible health
☐ Corrective Care – to relieve the symptoms and correct the underlying problem
☐ Symptomatic Care – to relieve the symptoms, but not to correct the underlying problem
☐ Maintenance Care – to maintain your current level of health
☐ Annual Physical Exam
☐ Check here if you want the Doctor to select the type of care appropriate to your condition

PATIENT NAME: **FILE #:**

EXAM DATE:

Please review the following lists of conditions. If you have had a condition in the past, check the "Past" box. If you currently have a conditions, check the "Now" box.

Past	Now	GENERAL	
☐	☐	Headaches	784.0
☐	☐	Fever	780.6
☐	☐	Chills	780.9
☐	☐	Night Sweats	780.8
☐	☐	Fainting	780.2
☐	☐	Dizziness	780.4
☐	☐	Convulsions	780.3
☐	☐	Loss of Sleep	780.52
☐	☐	Fatigue	780.7
☐	☐	Nervousness	799.2
☐	☐	Weight Loss	783
☐	☐	Pain/Numb limbs	782
☐	☐	Allergy	995.3
☐	☐	Wheezing	786.09
☐	☐	Neuralgia	729.2

Past	Now	GASTRO-INTESTINAL	
☐	☐	Poor Appetite	783
☐	☐	Poor Digestion	536.8
☐	☐	Excessive Hunger	994.2
☐	☐	Belching or Gas	787.3
☐	☐	Nausea	787
☐	☐	Vomiting	78
☐	☐	Vomiting Blood	578
☐	☐	Pain over Stomach	536.8
☐	☐	Constipation	564
☐	☐	Diarrhea	558.9
☐	☐	Colon Troubles	789
☐	☐	Hemorrhoids/Piles	455.6
☐	☐	Liver Trouble	785.1
☐	☐	Jaundice	782.4
☐	☐	Gall Bladder Trouble	575.9

Past	Now	EYE EAR NOSE THROAT	
☐	☐	Poor vision	368.9
☐	☐	Crossed Eyes	378.9
☐	☐	Pain in Eyes	379.91
☐	☐	Deafness	389.9
☐	☐	Earache	388.7
☐	☐	Ear Noises	388.3
☐	☐	Ear Discharges	388.6
☐	☐	Nasal Obstruction	478.1
☐	☐	Nose Bleeds	784.7
☐	☐	Sore Throat	462
☐	☐	Hoarseness	784.49
☐	☐	Hay Fever	477.9
☐	☐	Asthma	493.9
☐	☐	Frequent Colds	460
☐	☐	Enlarged Thyroid	240.9
☐	☐	Tonsillitis	463
☐	☐	Sinus Troubles	686.9

Past	Now	FOR WOMEN ONLY	
☐	☐	Painful Periods	786.2
☐	☐	Excessive Flow	626.2
☐	☐	Irregular Cycles	626.4
☐	☐	Hot Flashes	627.2
☐	☐	Cramps/Backache	625.3
☐	☐	Miscarriage	634.9
☐	☐	Vaginal Discharge	623.5
☐	☐	Pregnancy	

Past	Now	MUSCLES & JOINTS	
☐	☐	Weakness	
☐	☐	Twitching	
☐	☐	Stiff Neck	
☐	☐	Backache	722.10
☐	☐	Swollen Joints	719
☐	☐	Tremors	781
☐	☐	Foot Troubles	729.5
☐	☐	Painful Tail Bone	724.79
☐	☐	Pain betwn Shoulders	724.5
☐	☐	Hernia	553.9
☐	☐	Spinal Curvature	737.3

Past	Now	CARDIO-VASCULAR	
☐	☐	Rapid Heart	783
☐	☐	Slow Heart	427.89
☐	☐	High Blood Pressure	401.9
☐	☐	Low Blood Pressure	458.9
☐	☐	Pain over Heart	786.51
☐	☐	Heart Trouble	438
☐	☐	Ankle Swelling	719.07
☐	☐	Poor Circulation	459.9
☐	☐	Varicose Veins	
☐	☐	Strokes	436

Past	Now	SKIN OR ALLERGIES	
☐	☐	Skin Eruptions	368.9
☐	☐	Itching	698.9
☐	☐	Bruise Easily	287.8
☐	☐	Dryness	701.1
☐	☐	Boils	
☐	☐	Sensitive Skin	782
☐	☐	Hives/Allergy	708.9
☐	☐	Eczema	692.9
☐	☐	Medicines	

Past	Now	GENITAL/URINARY	
☐	☐	Frequent Urination	788.3
☐	☐	Pain on Urination	788.1
☐	☐	Blood in Urine	599.7
☐	☐	Kidney Infection	592
☐	☐	Bed Wetting	788.3
☐	☐	Can't control Urination	788.1
☐	☐	Prostate Trouble	601.9

Past	Now	RESPITORY	
☐	☐	Chronic Cough	786.2
☐	☐	Spitting Blood	786.3
☐	☐	Spitting Phlegm	933.1
☐	☐	Chest Pain	786.50
☐	☐	Difficulty Breathing	786.09

FAMILY HISTORY		Diabetes	Heart	Kidney	Cancer	Back
Mother:	☐ Living ☐ Deceased	☐	☐	☐	☐	☐
Father:	☐ Living ☐ Deceased	☐	☐	☐	☐	☐
Brothers:	How Many? ( )	☐	☐	☐	☐	☐
Sisters:	How Many? ( )	☐	☐	☐	☐	☐

Are you currently?	HABITS
☐	Smoking ______ packs/day
☐	Alcohol ______ drinks/day
☐	Coffee ______ cups/day
☐	No Exercise
☐	Moderate Exercise
☐	Daily Exercise (describe)

CHECK ANY DISEASES YOU HAVE HAD:

☐	Appendicitis	541	☐	Anemia	285.9	☐	Heart Disease	429.9	☐	Arthritis	716.9
☐	Pneumonia	541	☐	Measles	285.9	☐	Goiter	429.9	☐	Epilepsy	716.9
☐	Rheumatic Fever	541	☐	Mumps	285.9	☐	Influenza	429.9	☐	Mental Disorder	716.9
☐	Polio	541	☐	Chicken Pox	285.9	☐	Pleurisy	429.9	☐	Lumbago	716.9
☐	Tuberculosis	541	☐	Diabetes	285.9	☐	Alcoholism	429.9	☐	Eczema	716.9
☐	Whooping Cough	541	☐	Cancer	285.9	☐	Venereal Disease	429.9			

LIST ANY ALLERGIES YOU HAVE: