

Confidential Patient Health Record

DATE: _____	I.D. N.O. _____
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PERSONAL HISTORY

Name: _____ DOB: _____ SS# _____

Address: _____ Home # _____

City: _____ Work # _____ Cell # _____

State: _____ Zip: _____ E-mail: _____

Driver's License # _____ Age: _____ Sex: Male Female

Employer: _____ Occupation: _____

Business Phone: _____ E-Mail: _____

Name of Spouse: _____ Spouse's Social Security # _____

Spouse's Employer: _____ Business Phone: _____ Occupation: _____

Name/Number of Emergency Contact: _____ Relationship: _____

Referred to this office by: _____ Primary Care Physician: _____

Person responsible for your bill: You/Spouse Worker's Comp Auto Insurance Medicare Major Medical

Health Insurance Carrier: _____ I.D. Number: _____

Insured Person's Name: _____ Date of Birth: _____

CURRENT HEALTH CONDITION Unwanted Health Condition _____

Have you seen other Doctor's for this condition? _____ Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? _____

Is Condition Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Was the Accident reported to your employer and or insurance company? _____

Drugs you are currently taking: 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: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery

Broken Bones Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: None Doctor's Name & Approximate Date 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 as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you been tested HIV positive? Yes No

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
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling
- Stress

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not sure

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

ENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

Consent to Treat

Most patients that come to our office have one or two objectives in mind concerning their health care. 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.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date

Patient's Signature

If this is an ACCIDENT related injury, please fill out the ACCIDENT form. Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports 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. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays is for examination purposes only. The negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred in this office.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's Signature
Of Authorizing Care _____ Date _____