WELCOME TO OUR OFFICE

Please let us know if you require any assistance at all with this paper work!

We are here to help you!

CONFIDENTIAL PATIENT HEALTH RECORD

Date_____

Name _____ Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Sex: M F

Date of Birth _____ Age _____ Social Security # ____- ____ -_____

Your Employer _____ Type of work you perform_____

Business Phone # ( ) _____ Spouse's Name _____

Spouse's Employer _____ Spouses Social Security #____-___-___

Referred To This Office By _____

Name and # of Emergency Contact _____

Relationship of Contact _____

Who is responsible for your bill: You, Health Insurance, Auto Insurance, Work Comp

Medicare, Medicaid Other _____

Personal Health Insurance Name _____Card I.D.#_____

Insured Persons Name _____ Date of Birth _____

Email Address: _____

Current and Past Health Conditions

Please describe the purpose of this visit: _____

_____

When did this condition begin? _____

Is this condition related to an auto injury, work injury, home injury, sports injury

other injury? _____

Have you seen any other doctors for this condition? _____

If yes: who _____ when _____

What type of treatment did you receive? _____

Are you taking any medications?____ please list _____

Have you ever been hospitalized?____ For what and when? _____

_____

On a scale of 1-10, 1 being the worst and 10 the best, how do you presently feel?

(worst) 1 2 3 4 5 6 7 8 9 10 (best)

Have you ever had any surgeries or operations? _____

Have you ever had any fractures? _____

Have you ever had any previous accidents or injuries that required medical

treatment? _____

Have you had previous Chiropractic care? _____For what condition?_____

Doctors name and date of last visit _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Pneumonia	____	Influenza	____	Epilepsy	_____
Small Pox	____	Pleurisy	____	Lumbago	_____
Polio	____	Chicken Pox	____	Stroke	_____
Tuberculosis	____	Diabetes	____	Shingles	_____
Cancer	____	Arthritis	____	H.I.V.	_____
Anemia	____	Heart Disease	____		
Measles	____	Thyroid	____		

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

MUSCOLO-SKELETAL CODE

Low Back Pain	____
Pain Between Shoulders	____
Neck Pain	____
Arm Pain	____
Joint Pain/Stiffness	____
Walking Problems	_____
General Stiffness	____

GASTRO-INTESTINAL CODE

Gas/Bloating After Meals	____
Heartburn	____
Black/Bloody Stool	____
Colitis	____
Poor/Excessive Appetite	____
Excessive Thirst	____
Frequent Nausea	____
Vomiting	____
Diarrhea	____
Hemorrhoids	____
Liver Problems	____
Gall Bladder Problems	____
Weight Trouble	____
Abdominal Cramps	____
Constipation	_____

NERVOUS SYSTEM CODE

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

GENERAL CODE

Fatigue	____
Allergies	____
Loss of Sleep	____
Fever	____
Headache	____

GENITO-URINARY CODE

Bladder Trouble	_____
Painful/Excessive Urination	_____
Discolored Urine	_____

EENT CODE

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

MALE/FEMALE CODE

Menstrual Irregularity	_____
Menstrual Cramps	_____
Breast Pain/Lumps	_____
Prostate/Sexual Dysfunction	_____
Other problems	_____

C-V-R CODE

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

FAMILY HISTORY

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

Mother___Father____Brother ___Sister___ Child___

FEMALES ONLY:

When was your last period? _____ Are you pregnant? Yes ___ No ____ Not Sure _____

Most patients that come to our office have one of 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).

Relief care is the care that is necessary to get rid of your symptoms or pain, but not the cause of it. It is similar to drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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

Corrective Care **Relief Care**

Please be advised that when x-rays are taken in our office, we routinely send these films to a board certified Chiropractic radiologist for formal interpretation. This ensures that your x-ray films are being reviewed and interpreted by physicians who hold special qualifications to perform such readings. As a result, there may be additional fees incurred however, the benefits of having these films reviewed is a necessary part of your overall health care.

Patient Name (Print) _____

Patient (Signature) _____

Date _____

Guardian or legal representative if a minor _____

Date _____