Confidential Patient Health Record

Dear patient: Please complete this questionnaire. Your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. PLEASE PRINT NEATLY. Thank you.

Initial Date:_____ Reviewed_____ Reviewed_____ Reviewed_____

First:_____ **Middle**:_____ **Last**: _____ **Gender: Male / Female**
Address: _____**Apt #** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____
Fax #: (_____)_____-_____ **Email Address:** _____
Birth Date: ____ /_____/_____ **Age:**_____
Circle One: Divorced / Married / Single / Separated / Widowed
Spouses Name: _____
Ages of Children: _____

Employer
Business Name: _____ **Occupation/Job Title:** _____
Business Address: _____
Business Phone: (_____)_____-_____ **Type of Work:**_____

How were you referred to us? _____

Emergency Contact
Name: _____ **Phone Number**: (_____)_____-_____
Address: _____
Relationship:_____

Who Is Responsible For Your Bill?
□ **Self** □ **Worker's Comp** □ **Auto Insurance** □ **Medicare** □ **Medicaid** □ **Other (be specific**):_____
Personal Health Insurance Carrier: _____ **Health ID Card #:** _____
Insured Person's Name: _____ **Group #:** _____
Insured Person's Date of Birth: _____ **Primary Care Physician:** _____

Have you seen other doctors for current condition? ☐ **Yes** ☐ **No** **If yes, who? (Name)** _____
Location of Office: _____ **Type of Treatment:** _____
Were you satisfied with the results of your treatment? ☐ **Yes** ☐ **No** **Explain:** _____

Are you currently taking any prescription medications? ☐ **Yes** ☐ **No.** **If yes, please mark or list below (be specific).**
☐ **Allergy Medication** ☐ **Anti-Depressants** ☐ **Blood Pressure Medication** ☐ **Insulin** ☐ **Muscle Relaxers**
☐ **Nerve Pills** ☐ **Pain Killers** ☐ **Other (please be specific):** _____

Do you wear any of the following? ☐ **Heel Lifts** ☐ **Innersoles** ☐ **Arch Supports** ☐ **Orthotics**

Please list any other conditions you feel we should know about – even if unrelated: _____
_____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.
REVIEW OF SYSTEMS – Please fill out all of the sections, even if "DENY". Please put approximate date of onset or diagnosis next to any checked boxes.

Constitutional: **I…** ☐ **Deny Any Constitutional Issue (s)**
☐ **Chills** ☐ **Daytime Somnolence (Drowsiness)** ☐ **Fatigue** ☐ **Fever** ☐ **Night Sweats**
☐ **Weight Gain** ☐ **Weight Loss**

Eyes/Vision: **I…** ☐ **Deny Any Eyes/Vision Issue (s)**
☐ **Blindness** ☐ **Blurred Vision** ☐ **Cataracts** ☐ **Change in vision** ☐ **Double Vision**
☐ **Eye Pain** ☐ **Field Cuts (visual field defect)** ☐ **Glaucoma** ☐ **Itching (around the eyes)** ☐ **Photophobia**
☐ **Tearing** ☐ **Wears Glasses and/or Contact lenses**

Ears, Nose and Throat: **I…** ☐ **Deny Any Ears, Nose and Throat Issue (s)**
☐ **Bleeding** ☐ **Dental Implants** ☐ **Dentures** ☐ **Difficulty Swallowing** ☐ **Discharge**
☐ **Dizziness** ☐ **Ear Drainage** ☐ **Ear Infection(s)** ☐ **Ear Pain** ☐ **Fainting**
☐ **Headaches** ☐ **Head Injury (history of)** ☐ **Hearing Loss** ☐ **Hoarseness** ☐ **Loss of Smell**
☐ **Nasal Congestion** ☐ **Nose bleeds (frequent)** ☐ **Post Nasal Drip** ☐ **Rhinorrhea (Runny nose)** ☐ **Sinus Infections**
☐ **Snoring** ☐ **Sore Throats (frequent)** ☐ **Tinnitus (Ringing in Ears)** ☐ **TMJ problems**

Respiration: **I…** ☐ **Deny Any Respiratory Issue (s)**
☐ **Asthma** ☐ **Cough** ☐ **Coughing up blood** ☐ **Shortness of Breath** ☐ **Sputum Production** ☐ **Wheezing**

Cardiovascular: **I…** ☐ **Deny Any Cardiovascular Issue (s)**
☐ **Angina (chest pain or discomfort)** ☐ **Chest Pain** ☐ **Claudication (leg pain or achiness)** ☐ **Heart Murmor**
☐ **Heart Problems** ☐ **Orthopnea (difficulty breathing while lying down)** ☐ **Palpitations (irregular or forceful beating of the heart)**
☐ **Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)** ☐ **Shortness of Breath with Exertion or Exercise**
☐ **Swelling of Legs** ☐ **Ulcers** ☐ **Varicose Veins**

Gastrointestinal: **I…** ☐ **Deny Any Gastrointestinal Issue (s)**
☐ **Abdominal Pain** ☐ **Belching** ☐ **Black, Tarry Stools** ☐ **Constipation** ☐ **Diarrhea**
☐ **Difficulty Swallowing** ☐ **Heartburn** ☐ **Hemorrhoids** ☐ **Indigestion** ☐ **Jaundice (yellowing of the skin)**
☐ **Nausea** ☐ **Rectal Bleeding** ☐ **Abnormal Stool Caliber (quality)** ☐ **Abnormal Stool Color**
☐ **Abnormal Stool Consistency** ☐ **Vomiting** ☐ **Vomiting Blood**

Female: **I…** ☐ **Deny Any Female Issue (s)**
☐ **Birth Control Therapy** ☐ **Breast Lumps/Pain** ☐ **Burning Urination** ☐ **Cramps** ☐ **Frequent Urination**
☐ **Hormone Therapy** ☐ **Irregular Menstruation** ☐ **Urine Retention** ☐ **Vaginal Bleeding** ☐ **Vaginal Discharge**

Male: **I…** ☐ **Deny Any Male Issue (s)**
☐ **Burning Urination** ☐ **Erectile Dysfunction** ☐ **Frequent Urination** ☐ **Hesitancy/Dribbling** ☐ **Prostate Problems**
☐ **Urine Retention**

Endocrine: **I… ☐ Deny Any Endocrine Issue (s)**

☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Excessive Thirst
☐ Frequent Urination ☐ Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth ☐ Voice Changes

Skin: **I… ☐ Deny Any Skin Issue (s)**

☐ Changes in Nail Texture ☐ Changes in Skin Color ☐ Hair Growth ☐ Hair Loss ☐ Hives ☐ Itching
☐ Paresthesia (numbness, prickling, or tingling) ☐ Rash ☐ History of Skin Disorders ☐ Skin Lesions/Ulcers ☐ Varicosities

Nervous System: **I… ☐ Deny Any Nervous System Issue (s)**

☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors ☐ Unsteadiness of Gait

Psychological: **I… ☐ Deny Any Psychological Issue (s)**

☐ Anhedonia (inability to experience joy or enjoy life) ☐ Anxiety ☐ Appetite Changes ☐ Behavioral Change(s)
☐ Bipolar Disorder ☐ Confusion ☐ Convulsions ☐ Depression ☐ Insomnia ☐ Memory Loss
☐ Mood Change(s)

Allergy: **I… ☐ Deny Any Allergy Issue (s)**

☐ Anaphylaxis (history of) ☐ Food Intolerance ☐ Itching ☐ Nasal Congestion ☐ Sneezing

Hematology: **I… ☐ Deny Any Hematological Issue (s)**

☐ Anemia ☐ Bleeding ☐ Blood Clotting ☐ Blood Transfusion(s) ☐ Bruises easily ☐ Fatigue ☐ Lymph Node Swelling

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PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: **I… ☐ Deny Any Childhood Illness(es)** (Please put approximate date of onset next to any checked boxes)

☐ ADD ☐ Allergies/Hay fever ☐ Asthma ☐ Atopic Dermatitis (Eczema) ☐ Bedwetting
☐ Cerebral Palsy ☐ Chicken Pox ☐ Depression ☐ Diabetes ☐ Ear Infections
☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches ☐ Hepatitis ☐ HIV
☐ Measles ☐ Mumps ☐ Rash ☐ Scoliosis ☐ Seizure Disorder
☐ Sickle Cell Anemia ☐ Spina Bifida ☐ Other (please describe): _____

Adult Illness: **I… ☐ Deny Any Adult Illness (es)** (Please put approximate date of onset next to any checked boxes)

☐ Alzheimer's ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Anxiety*
☐ Cancer* ☐ Crohn's/Colitis ☐ CRPS (RSD) ☐ CVA (stroke)* ☐ Cystic Kidney Disease
☐ Depression* ☐ Diabetes (Insulin)* ☐ Diabetes (Non insulin)* ☐ Ear Infections (frequent) ☐ Emphysema
☐ Eye Problems ☐ Fibromyalgia ☐ Heart Disease ☐ Hepatitis ☐ HIV
☐ Hypertension ☐ Influenzal Pneumonia ☐ Liver Disease ☐ Lung Disease ☐ Lupus Erythema (discoid)
☐ Lupus Erythema (systemic) ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Pleurisy ☐ Pneumonia
☐ Psychiatric Problems ☐ Scoliosis ☐ Seizure Disorder ☐ Shingles ☐ STD's (unspecified)
☐ Suicide Attempt(s) ☐ Thyroid Problems ☐ Vertigo
☐ Past history of similar symptoms to your current condition ☐ Other Illness (please be specific): _____

Surgeries: **I… ☐ Deny Any Surgery (ies)** (Please put approximate date of onset next to any checked boxes)

☐ Angioplasty ☐ Appendectomy ☐ Caesarian Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair
☐ Coronary Artery Bypass ☐ Cosmetic ☐ D & C ☐ Dental Surgery ☐ Gallbladder
☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Reconstruction ☐ Joint Replacement
☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Rotator Cuff ☐ Spinal Fusion
☐ Tonsillectomy ☐ Other (please be specific): _____

Ob/Gyn: **I… ☐ Deny Any Ob/Gyn Issue (s)**

I… ☐ have never been pregnant ☐ have been pregnant in the past ☐ am currently pregnant
_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____

My menses is ☐ Regular ☐ Irregular; I am currently in ☐ Metaphase ☐ Menopause; Date of Last Menses _____/_____/_____

Injuries: **I… ☐ Deny Any Injury (ies)** **(Please put approximate date next to any checked boxes)**

☐ **Back Injury** ☐ **Broken Bones** ☐ **Severe Fall** ☐ **Fracture** ☐ **Disability**
☐ **Head Injury** ☐ **Industrial Accident** ☐ **Joint Injury** ☐ **Severe Laceration** ☐ **Motor Vehicle Accident**
☐ **Mild/Moderate Soft Tissue Injury** ☐ **Severe Soft Tissue Injury** ☐ **Other (please be specific):_____**

Immunizations: **I… ☐ Deny Any Immunization (s)**

☐ **DTaP(diphtheria, tetanus, and pertussis)** ☐ **Flu** ☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **Hepatitis C**
☐ **Influenza** ☐ **IPV (Polio)** ☐ **MMR (measles, mumps, and rubella)** ☐ **Pneumococcal** ☐ **Varivax**
☐ **PPD (Mantoux Test-TB)** ☐ **Small Pox** ☐ **TB** ☐ **Varivax (chicken pox)** ☐ **Whooping Cough (Pertussis)**

Non-Drug Allergies: **I… ☐ Deny Any Non-Drug Allergy(ies)**

☐ **Animals** ☐ **Dairy** ☐ **Eggs** ☐ **Food Coloring** ☐ **Mold** ☐ **Pollen** ☐ **Wheat**
☐ **Other (please be specific): _____**

Family History

					Condition (please be specific)
General Family	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Father	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Mother	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Paternal Grandfather	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Paternal Grandmother	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Maternal Grandfather	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Maternal Grandmother	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Son (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Daughter (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Brother (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____
Sister (s)	☐ Alive	☐ Deceased;	☐ Normally Developed	☐ No Significant Disease	☐ Has/Had: _____

Social History

Alcohol: ☐ Never ☐ Social Consumption only ☐ Beer ☐ Liquor ☐ Wine ; _____ oz ____ glasses; ☐ Day ☐ Week ☐ Month
Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt
☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar
Education (please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High ☐ Vo-tech
☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐ Post High School Classes ☐ Assoc/Technical Degree
☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate ☐ Other: _____
Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _____ ☐ Have used drugs for _____
Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking
☐ Smoke; # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew; #_____cans per ☐ Day ☐ Week ☐ Year
☐ Electronic Cigarette (Vape)

I DO HEREBY CERTIFY THAT ALL OF MY STATEMENTS ON THIS HEALTH CARE RECORD ARE TRUE, ACCURATE AND COMPLETE.

_____ _____
Signature **Date**