Confidential Patient Health Record Date I.D. No.

PERSONAL HISTORY

Name: _____ Birth Date: _____ Age: _____ Sex: M / F

Address: _____City: _____ State: ____ Zip Code: _____

Home Phone: _____ Social Security # _____ Martial Status: S M D W

Employer: _____ Occupation: _____

Business Phone: _____ May we contact you at work YES or NO

Mobile Phone: _____May we contact you at this number YES or NO

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

Spouse's Employer: _____ Occupation: _____

Business Phone: _____

Name of Children: _____Ages of Children: _____

Referred to this office by: _____

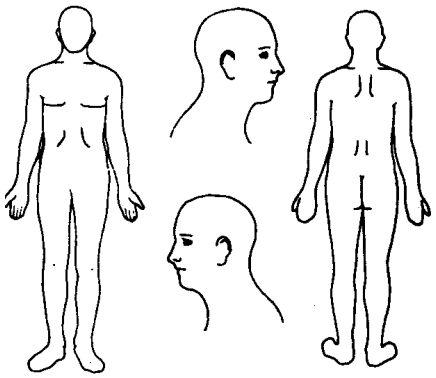
Name and Number of Emergency Contact: _____ Relationship: _____

Who is responsible for you bill, Circle One: You, Worker's Comp, Auto Insurance, Medicare, Health Insurance

Name of Insurance: _____

Insured Person's Name: _____Date of Birth: _____ Social Security # _____

CURRENT HEALTH CONDITION



Primary Health Complaint:

_____

_____

Other Doctors seen for this condition: Yes/No Who?

_____

Type of Treatment: _____

Results: _____

When did this condition begin? _____

Has this condition occurred before Yes/No

Is condition: Job related/ Auto Accident, Home injury, fall, other:

_____

Date of Accident: _____ Time of Accident: _____

Have you made a report of your accident to your employer: Yes/No

Do you now take: Nerve pills, Pain killers/ muscle relaxers, blood pressure medicine, insulin, other: _____

PAST HEALTH HISTORY-Please Circle and Describe**:**

Major surgery/operations: Appendectomy, Tonsillectomy, Gall Bladder, Hernia, Back surgery, Broken Bones, Other:

_____

Major Accident or Falls: _____

_____

Hospitalization (other than above): _____

Previous Chiropractic Care: If yes doctors name & date of last visit:

_____

Below are lists 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.

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Pneumonia	Mumps	Influenza	INTAKE
Rheumatic Fever	Small Pox	Pleurisy	Coffee
Polio	Chicken Pox	Arthritis	Tea
Tuberculosis	Diabetes	Epilepsy	Alcohol
Whooping Cough	Cancer	Mental Disorders	Cigarettes
Anemia	Heart Disease	Lumbago	White Sugar
Measles	Thyroid	Eczema	

Have you been tested HIV positive? Y/N

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

Musculo-Skeletal

Low Back Pain	Pain Between Shoulders	Neck Pain
Arm Pain	Joint Pain/Stiffness	Walking Problems
General Stiffness	Difficult Chewing/Clicking Jaw	

Nervous System

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

General

Fatigue	Allergies	Loss of Sleep
Fever	Headaches	

Gastro-Intestinal

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

Genito-Urinary

Bladder Trouble	Painful/Excessive urination	Discolored Urine

C-V-R

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

EENT

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

Female

Menstrual Irregularity
Vaginal Pain/Infection
Menstrual Cramps
Breast/Pain Lumps
Other Problems

Male

Prostate/Sexual Dysfunction ale

FEMALES ONLY: When was your last period? _____ Are you pregnant? YES or NO