# Confidential Patient Health Record

***Today's Date*:___/____/_____**

## *Personal Information*

**Last:_____ First:_____ Middle:_____**

**Birth Date: ____ /____/_____ Age:_____ Sex: Male / Female Social Security #: _____-_____-_____**

**Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated**

**Address: _____Apt # _____**

**City: _____ State: _____ Zip: _____**

**Work Phone: (_____) _____-_____ ext _____ Cell Phone: (_____) _____-_____ ext _____**

**Email Address: _____**

## *Emergency Contact*

**Last:_____ First:_____ Middle:_____**

**Address: _____Apt # _____**

**City: _____ State: _____ Zip: _____**

**Relationship: □ Spouse □ Relative □ Friend □ Other _____**

**Email Address: _____**

**Home Phone: (_____) _____-_____ ext _____ Cell Phone: (_____) _____-_____ ext _____**

**Work Phone: (_____) _____-_____ ext _____**

## *Current Health Condition*

**Unwanted Condition (Why you are here today?):_____**

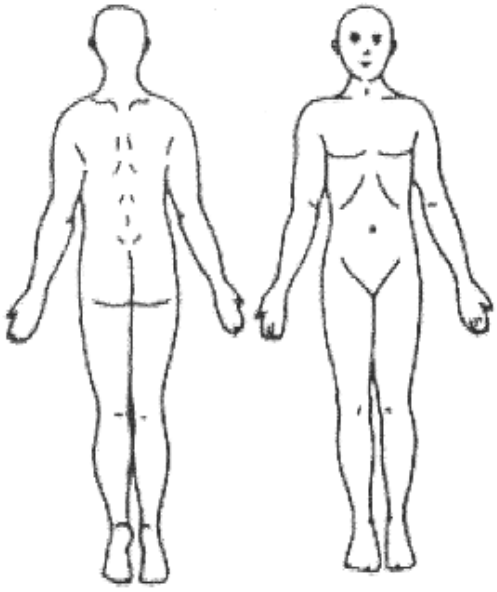
**_____**

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**

**→ → → → →**

**Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.**

**Key: A=Ache B=Burning N = Numbness**
**P=Pins & Needles S=Stabbing**



**When did this Condition BEGIN? _____/_____/_____**

**Is the Condition: □ Auto Related □ Job Related □ Home Injury**

**□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other**

**Explain: _____**

**_____**

**Date of Accident: _____ Condition/Pain STARTED on what Date: _____**

**Do you SUFFER with ANY OTHER Condition than which you are now consulting us?**

**_____**

**_____**

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

***Previous Care for this Same Condition:***

☐ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

**Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____**

***Previous Chiropractic Care:*** ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

**Doctor's Name: _____ Location: _____ Date of Last Visit: __ _____**

***Current Medication (s):*** **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

| Medication | Dosage | For What Condition? | How long have you been taking this? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***Adult Illness (es):*** **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ arthritis
☐ asthma
☐ cancer
☐ cerebral palsy
☐ CVA (stroke)
☐ diabetes
☐ eczema
☐ ephysema
☐ eye problems
☐ fibromyalgia
☐ heart disease
☐ hepatitis
☐ hypertension
☐ multiple sclerosis
☐ parkinson's disease
☐ unspecified pleural effusion
☐ HIV
☐ scoliosis
☐ seizures
☐ thyroid problems
☐ vertigo

***Surgery (ies):*** **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty
☐ cardic catheterization
☐ carpal tunnel repair ☐ coronary artery bypass
☐ joint reconstruction
☐ joint replacement
☐ knee repair
☐ laminectomy
☐ mastectomy
☐ cosmetic
☐ D & C
☐ dental sugery
☐ gall bladder
☐ hernia repair
☐ pacemaker insertion
☐ rotator cuff
☐ spinal fusion
☐ tonsilectomy

***Injury (ies):*** **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury
☐ broken bones
☐ disability (ies)
☐ fall (severe)
☐ fracture
☐ head injury (loss of consciousness)
☐ head injury (no loss of consciousness)
☐ industrial accident
☐ joint injury
☐ laceration (severe)
☐ motor vehicle accident
☐ soft tissue injury (mild)
☐ soft tissue injury (moderate)
☐ soft tissue injury (severe)
☐ other:

**1. It is our office policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.**

**2. All payments are expected at the time of service. Patient's balances may not exceed $150.00 at any time.**

**3. All insurance assignment patients must pay their deductible in full and the co insurance at the time of services or at the end of the week. Insurance assignment patient's balances may not exceed $150.00 at any time.**

**4.There will be a $35.00 fee imposed for all checks returned to this office.**

**5. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1 ½% per month. Charges may also be made for missed appointments and those not cancelled without a 2-hour notice.**

**I also understand that if I suspend or terminate my care or treatment, 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 through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. I consent to the chiropractic treatment(s)offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine, pelvis and extremities. I intend this consent to apply to all my present and future treatments at this clinic.**

**Patient Print Name: _____ Patient's Signature: _____ Date: _____**

**Consent to treat a Minor: _____ Date: _____**
**Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____**

**I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.**

**Patient Print Name: _____ Date: _____**
**Patient's Signature: _____ Date: _____**