Confidential Patient Health Record

Date: ___/___/_____

Circle One: Divorced Married Single Separated Widowed Birth Date: ____/____/_____ Age: _____

First: _____ Middle: _____ Last: _____ Gender: Male / Female

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

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

Email Address: _____

Emergency Contact

Name: _____ Phone Number: (_____)_____-_____

Address: _____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

_____

_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No

When? _____

Is the condition: ☐ Auto Related ☐ Work Related
☐ No Injury ☐ Other

Explain: _____

_____

Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

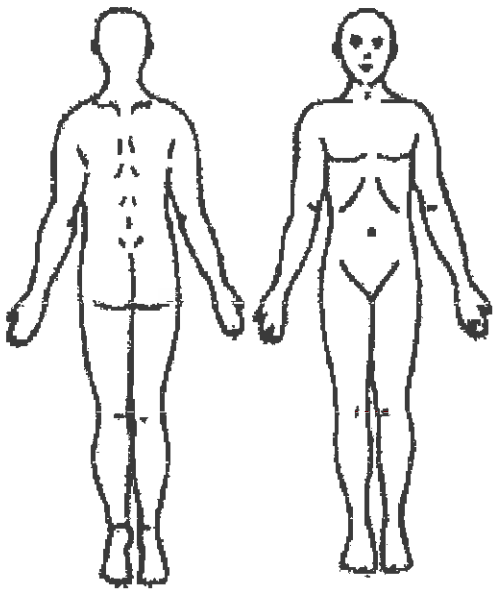
If Work Related:

Have you filed an injury report with your employer? ☐Yes ☐ No

Claim #: _____

Use the letters below to indicate the type and location of you sensations right now:

A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other



Have you seen other doctors for this condition? ☐ Yes ☐ No

If yes, Who? (Name) _____

Are you currently taking any prescription medications? ☐ Yes ☐ No

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

_____

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

Adult Illness: I… ☐ Deny Any Adult Illness (es)

☐ Anemia ☐ Arthritis ☐ Cancer ☐ CVA (stroke) ☐ Diabetes (Insulin) ☐ Diabetes (Non insulin)
☐ Fibromyalgia ☐ Heart Disease ☐ Hepatitis ☐ HIV ☐ Hypertension ☐ Multiple Sclerosis
☐ Parkinson's Disease ☐ Scoliosis ☐ Seizure Disorder ☐ Thyroid Problems ☐ Vertigo
☐ Past history of similar symptoms to your current condition ☐ Other Illness (please be specific): _____

Surgeries: I… ☐ Deny Any Surgery (ies)

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

Injuries: I… ☐ Deny Any Injury (ies)

☐ 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

Social History

Alcohol: ☐ Never ☐ Social Consumption only
Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke ☐ Smoke; # _____ per ☐ Day ☐ Week

Office Policy

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 this office accepts insurance assignment.
2. All payments are expected at the time of service.
3. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service or at the end of the week. Insurance assignment patient's balances may not exceed $150.00 at any time.
4. Balances over 30 days may be subjected to an additional 3% per month.
5. Charges may be charged 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 to me will be immediately due and payable.

Consent to Treatment

I hereby authorize the physician to trat 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 be by the 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 appointments at this clinic.

Patient
Name: _____ Date: _____

Consent to treat a minor: _____
Guardian: _____

NAME: _____ DATE: _____

ACTIVITIES DISCOMFORT SCALE

In the boxes below, mark the appropriate statements with an "X".

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or Jogging					
8. Climbing stairs					
9. Carrying					
10. Pushing and pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household chores					
16. Gardening					
17. Sports					
18. Employment					