



# CONFIDENTIAL PATIENT HEALTH RECORD

NEW PATIENT  
 REACTIVATE  
 OTHER

PLEASE PRINT: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

STREET/P.O. BOX: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

SOC. SEC. #: \_\_\_\_\_ DRIVER'S LICENSE: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SPOUSE'S OCCUPATION/EMPLOYER: \_\_\_\_\_

NAMES/AGES OF CHILDREN AT HOME: \_\_\_\_\_

WHO REFERRED YOU?: \_\_\_\_\_

WHO SHOULD WE NOTIFY IN AN EMERGENCY?: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

CARD HOLDER INFORMATION:

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

SOC. SEC. #: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_

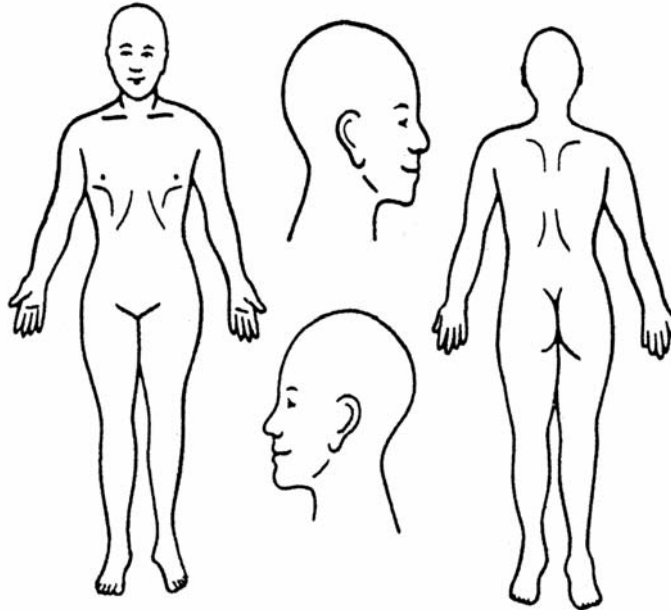
INSURANCE COMPANY ADDRESS: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

## CHIEF COMPLAINT

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation. Use the appropriate symbols. If there is more than one area of discomfort, please rate the pain on a scale of 1 to 100 next to each area, 0 being no pain and 100 being intolerable pain.

- XXX BURNING (BU)
- (((( ACHING, PAIN (AC)
- 000 PINS & NEEDLES (PI)
- ... NUMBNESS (NU)
- ::: SHARP PAIN (SH)



YES NO

DOES THE PAIN INTERFERE WITH YOUR SLEEP? HOW MANY TIMES DO YOU WAKE UP? \_\_\_\_\_

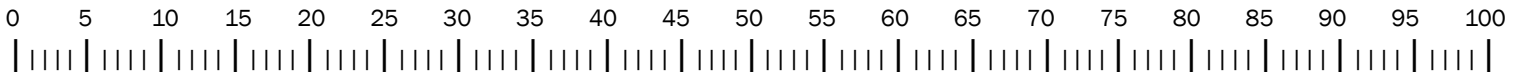
DOES IT CAUSE PAIN TO COUGH/GRUNT/SNEEZE? WHERE? \_\_\_\_\_

YES NO

DOES COLD AFFECT THE PAIN? HOW? \_\_\_\_\_

DOES HEAT AFFECT THE PAIN? HOW? \_\_\_\_\_

FOR OFFICE USE ONLY:	
___ CONSTANT	
___ COME/GO	
___ GETTING BETTER	
___ GETTING WORSE	
___ STAYING SAME	
BETTER:	WORSE:
___ AM	___
___ MIDDAY	___
___ PM	___



SYMPTOMS DEVELOPED FROM:  WORK-RELATED INJURY  AUTO ACCIDENT  OTHER \_\_\_\_\_

WHEN DID THEY BEGIN? \_\_\_\_\_ HOW DID IT OCCUR? \_\_\_\_\_

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THESE CODES:  
 U - UNABLE L - UNITED P - PAINFUL D - DIFFICULT N - NORMAL H - HAVEN'T TRIED

- |                                   |                         |                                 |                                       |
|-----------------------------------|-------------------------|---------------------------------|---------------------------------------|
| 1. ___ LYING ON BACK              | 7. ___ GRIPPING         | 13. ___ PUSHING                 | 19. ___ BENDING FORWARD TO BRUSHTEETH |
| 2. ___ LYING ON SIDE W/KNEES BENT | 8. ___ CLIMBING         | 14. ___ KNEELING                | 20. ___ STANDING MORE THAN ONE HOUR   |
| 3. ___ TURNING OVER IN BED        | 9. ___ PULLING          | 15. ___ STOOPING                | 21. ___ BALANCING                     |
| 4. ___ GETTING IN/OUT OF CAR      | 10. ___ DRESSING SELF   | 16. ___ SITTING AT TABLE        | 22. ___ COUGH/SNEEZE/GRUNT            |
| 5. ___ LYING FLAT ON STOMACH      | 11. ___ SEXUAL ACTIVITY | 17. ___ BENDING FORWARD         | HOW? _____                            |
| 6. ___ REACHING                   | 12. ___ SLEEPING        | 18. ___ WALKING SHORT DISTANCES | WHERE? _____                          |

## QUESTIONS FOR HEADACHE

YES NO

DO YOU EXPERIENCE:

- NAUSEA, VOMITING, OR VISUAL DISTURBANCES?  
  PAIN OR CRACKING IN JAW?  
  ABNORMAL BLOOD PRESSURE?  
  FAMILY HISTORY OF HEADACHES?  
 FREQUENCY OF HEADACHES: \_\_\_\_\_  
 LAST EYE EXAM BY AN EYE DOCTOR: \_\_\_\_\_

## QUESTIONS FOR LUMBOSACRAL SPINE (LOWBACK)

YES NO

- FEELING OF RIPPING OR TEARING?  
 WHERE? \_\_\_\_\_  
  DOES PAIN RADIATE IN THE ABDOMEN?  
  IMPAIRMENT OF BOWELS OR URINARY FUNCTION?  
 EXPLAIN: \_\_\_\_\_

## QUESTIONS FOR CERVICAL SPINE (NECK)

YES NO

- NECK INJURY THAT AFFECTS HEARING, VISION, BALANCE, OR CAUSES RINGING IN EARS?  
  DO YOU HEAR GRATING SOUNDS?

YES NO

- DIFFICULTY TURNING HEAD?  RIGHT  LEFT  
  PAIN/PRESSURE BEHIND EYE?  
 FEELING OF RIPPING OR TEARING?  
 WHERE? \_\_\_\_\_

- HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE?

DATE	DR. NAME	CONDITION	RESULTS
1.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS
2.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS

- HAVE YOU EVER SEEN A DOCTOR FOR THE CONDITION?

DATE	DR. NAME	CONDITION	RESULTS
1.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS
2.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS

- ALLERGIES? TO WHAT? \_\_\_\_\_

- DO YOU NOW TAKE PRESCRIPTION DRUGS, OVER-THE-COUNTER DRUGS, VITAMINS, OR SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
1.				
2.				
3.				

- HAVE YOU EVER HAD ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS. AUTO ACCIDENTS. OR SURGERIES?

DATE	INJURY/ILLNESS	TREATMENT	RESULTS
1.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS
2.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS
3.			<input type="checkbox"/> COMPLETE RECOVERY <input type="checkbox"/> COMPLICATIONS

STATUS:  MALE  FEMALE  SINGLE  MARRIED  OTHER \_\_\_\_\_ STUDENT:  FULL-TIME  PART-TIME

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

WORK HOURS PER WEEK: \_\_\_\_\_ RECREATIONAL ACTIVITIES (HOBBIES): \_\_\_\_\_

- DO YOU COMMUTE TO WORK? HOW FAR? \_\_\_\_\_

- DO YOU EXERCISE \_\_\_ TIMES PER \_\_\_\_\_

- ARE YOU A SMOKER? \_\_\_\_\_ PACKS PER DAY? \_\_\_\_\_

- DO YOU CONSUME CAFFEINE? \_\_\_\_\_ HOW MUCH PER DAY \_\_\_\_\_

- DO YOU CONSUME ALCOHOL? \_\_\_\_\_ GLASSES PER DAY/WEEK \_\_\_\_\_

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES OR N FOR NO IN EACH OF THE FOLLOWING.)

- |                                  |                       |                         |
|----------------------------------|-----------------------|-------------------------|
| 1. ___ EYES                      | 6. ___ URINARY        | 11. ___ INTERNAL ORGANS |
| 2. ___ EARS, NOSE, MOUTH, THROAT | 7. ___ MUSCLES        | 12. ___ BLOOD           |
| 3. ___ HEART                     | 8. ___ NERVES         | 13. ___ ALLERGIES       |
| 4. ___ LUNGS/BREATHING           | 9. ___ SKIN           | 14. ___ OTHER _____     |
| 5. ___ INTESTINES                | 10. ___ PSYCHOLOGICAL |                         |

PLEASE DESCRIBE: \_\_\_\_\_

MY SIGNATURE IS AN ACKNOWLEDGEMENT OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT IS SO APPROVED.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

D.C./C.A. SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_