Confidential Patient Health Record

Today's Date: ______/______/______

Personal Information (Please Print)

Whom may we thank for referring you to us? ____

Last: ______________________________ **First:** ______________________________ **Middle:** _________

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

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

Address: ____ **Apt #** __________

City: ____ **State:** __________ **Zip:** __________________

Home Phone: (_______) _______-_______ **Work Phone:** (_______) _______-_______ **ext** _______

Cell Phone: (_______) _______-_______ **Email:** ____

Spouses Name: ____ **Number of Children:** _______________

Primary Physician: __________________________________ **Clinic:** ______________________________

Emergency Contact

Last: ______________________________ **First:** ______________________________ **Middle:** _________

Address: ____ **Apt #** __________

City: ____ **State:** __________ **Zip:** __________________

Home Phone: (_______) _______-_______ **Cell Phone:** (_______) _______-_______ □ Spouse □ Relative □ Other

Insurance Information

Who is responsible for your bill? YOU and… (mark appropriate boxes) □ Myself ONLY

□ Spouse □ Worker's Comp □ Auto Insurance □ Medicare □ Medicaid □ Other Insurance

Insurance Carrier: ___________________________ **Policy Holder's Name:** ________________________________

Policy Holder's SSN ______ - ______ - ______ **Policy Holder's DOB:** ______/______/______

Current Health Condition

Please list your:

Primary Complaint: _____________________________ **When did it start?** _________________________________

How Often? ________________________________ **Getting Worse?** ____________ **Getting Better?** ____________

What activity bothers it the most? ____

When is it at its best? ___________________________ **When is it at its worst?** _____________________________

Rate the pain: (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Secondary Complaint: _____________________________ **When did it start?** _______________________________

How Often? ________________________________ **Getting Worse?** ____________ **Getting Better?** ____________

What activity bothers it the most? ____

When is it at its best? ___________________________ **When is it at its worst?** _____________________________

Rate the pain: (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Other health complaints: ____

Health History ...*Continued*

List ALL medications you are currently taking: ____

____

What kind of exercise do you do? ____

What supplements do you take? ____

Please check all that apply

Head:
- □ Headache
  - □ Sinus
  - □ Migraine
- □ Light - headedness
- □ Loss of balance
- □ Dizziness
- □ Ringing in ears

Neck:
- □ Pain in neck
- □ Neck pain w/movement
- □ Pinched nerve in neck
- □ Neck feels out of place
- □ Muscle spams in neck
- □ Grinding sounds in neck
- □ Popping sounds in neck
- □ Arthritis in neck

Shoulders:
- □ Pain in shoulder joint
- □ Pain across shoulders
- □ Can't raise arm
  - □ above shoulder level
  - □ over head
- □ Tension in shoulders
- □ Pinched nerve in shoulders
- □ Muscle Spasm in shoulders

Arms & Hands:
- □ Pain in upper arm
- □ Pain in elbow
- □ Tennis elbow
- □ Pain in forearm
- □ Pain in hands
- □ Pain in fingers
- □ Pins & needles in arms
- □ Pins & needles in fingers
- □ Hands Cold
- □ Swollen joins in fingers
- □ Arthritis in fingers
- □ Loss of grip strength

Mid Back:
- □ Mid back pain
- □ Pain between shoulders
- □ Dull ache
- □ Muscle spasm
- □ Pain in kidney area

Chest:
- □ Chest pain
- □ Shortness of breath
- □ Pain around ribs

Abdomen:
- □ Nervous stomach
- □ Heartburn
- □ Nausea
- □ Gas
- □ Constipation
- □ Diarrhea

Low Back:
- □ Low back pain
- □ Pain is worse when
  - □ Working
  - □ Lifting
  - □ Stooping
  - □ Standing
  - □ Sitting
  - □ Bending
  - □ Coughing
  - □ Lying Down
  - □ Walking
- □ Muscle spasm
- □ Arthritis

Hips,Legs & Feet:
- □ Pain in buttocks
- □ Pain in hips
- □ Pain down leg
- □ Knee Pain
  - □ Inside
  - □ Outside
- □ Leg cramps
- □ Cramps in feet
- □ Pins & needles in legs
- □ Numbness of legs
- □ Numbness of feet
- □ Numbness of toes
- □ Feet feel cold

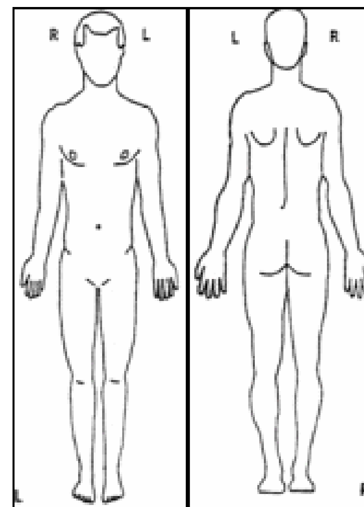
General:
- □ Depressed
- □ Fatigue
- □ Loss of sleep
- □ Coffee ______cups/day
- □ Tea ______cups/day
- □ Cigarettes ______ a day
- □ Diabetes
- □ Hypoglycemia

Other Conditions:

____

____

Mark Pain Areas:



Please read and sign below

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collections from the insurance company. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

***All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I hereby authorize the doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.**

Patient's Signature: ______________________________________ **Date:** ______/______/______