Confidential Patient Health Record

(Please Print)

New Patient ☐
Reactivate ☐
Other ☐

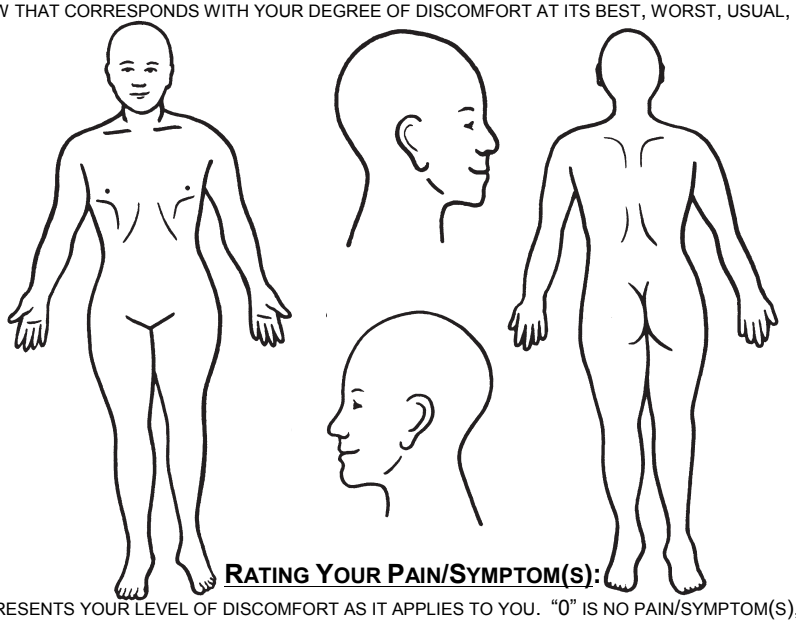
Name: _____ Date: _____
Street Address / P.O. Box _____ Home Phone: _____
City / State / Zip: _____ Mobile Phone: _____
Social Security Number: _____ Work Phone: _____
Your Employer: _____ Birthdate: _____
Marital Status: _____ Email: _____
Spouse's Name: _____ Spouse's Employer: _____
Names / Ages of Children: _____
Who Should We Notify in an Emergency? _____ Relationship: _____ Phone #: _____
Who is Your Medical Doctor? _____ Facility / City: _____
How Were You Referred? ☐My M.D. ☐Ins. Plan ☐Another Person: _____ Other: _____

History of Present Illness / Injury

Chief Complaint(s)

Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Circle the number below that corresponds with your degree of discomfort at its best, worst, usual, & right now.

X X X Burning Pain
((((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain



Please Complete:

_____ Constant
_____ Come & Go
_____
_____ Getting Better
_____ Getting Worse
_____ Staying Same
_____

Better:	Worse:
_____ AM	_____
_____ Mid-Day	_____
_____ PM	____

Rating Your Pain/Symptom(s):

Enter the number that best represents your level of discomfort as it applies to you. "0" is no pain/symptom(s), "100" is intolerable.

Neck (Rate 0-100):	**Mid Back** (0-100):	**Low Back** (0-100):	_____:	_____:	_____:
Now: _____	Now: _____	Now: _____	Now: _____	Now: _____	Now: _____
Best: _____	Best: _____	Best: _____	Best: _____	Best: _____	Best: _____
Worst: _____	Worst: _____	Worst: _____	Worst: _____	Worst: _____	Worst: _____
Usual: _____	Usual: _____	Usual: _____	Usual: _____	Usual: _____	Usual: _____

What Makes the Condition Better?

Head / Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

What Makes the Condition Worse?

Head / Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

How Did It Occur? ☐ Work – Related Injury ☐ Auto Accident ☐ Other: _____
When Did They Begin? _____ Have You Missed Work? ☐Yes ☐No How Much? _____

Indicate Your Ability to Perform the Following Activities. Please Use the Following Codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

1. _____ Lying on Back
2. _____ Lying on Sides
3. _____ Lying on Stomach
4. _____ Turning Over in Bed
5. _____ Stooping
6. _____ Using Stairs/Ladder
7. _____ Gripping
8. _____ Pushing / Pulling
9. _____ Reaching
10. _____ Dressing Self
11. _____ Sexual Activity
12. _____ Getting In / Out of Car
13. _____ Sitting/Driving/Riding
14. _____ Using a Computer
15. _____ Kneeling
16. _____ Walking
17. _____ Standing
18. _____ Bending Forward
19. _____ Lifting
20. _____ Cough / Sneeze/ Grunt

YES NO

- ☐ ☐ Does the Discomfort Interfere with your Sleep?
  - ♦How Many Times Does It Wake You Up? _____
- ☐ ☐ Do You Sleep with a Pillow? How Many? _____
  - ♦Where? _____
  - ♦What Positions Do You Sleep In? _____
  - ♦How Old is Your Mattress? _____
- ☐ ☐ Does Using Heat Affect the Pain? How? _____
- ☐ ☐ Does Using Cold Affect the Pain? How? _____
- ☐ ☐ Do You Wear a Heel Lift? Which Side? (**Left** or **Right**)
- ☐ ☐ Do You Wear Foot Orthotics?
- ☐ ☐ Have you Had X-Rays of the Problem Area(s)?
  - ♦When? _____
  - ♦Facility? _____
  - ♦Body Part(s)? _____

Females: Are You Pregnant? ☐ Yes ☐ No

Due Date: _____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

Males: Date of Last Prostate & Testicular Exam: _____

Neck & Headache Questions

YES NO

- ☐ ☐ Difficulty Turning Head? ☐ Left ☐ Right
- ☐ ☐ Do You Hear Grating / Crackling Sounds?
- ☐ ☐ Was There a Feeling of Ripping or Tearing?
- ☐ ☐ Do You Try to "Crack" Your Own Neck?
- ☐ ☐ Do You Get Pain or Cracking in Jaw?
- ☐ ☐ Family History of Headaches?
- ☐ ☐ Do You have Nausea, Vomiting, Visual Disturbances, Altered Hearing, Ringing in Ears, or Loss of Balance?
- ☐ ☐ Do You Pain or Pressure Behind the Eye(s)? Rt or Lt
- ☐ ☐ Do You Have Abnormal Blood Pressure?

♦Frequency of Headaches: _____ per _____

♦Date of Last Eye Exam: _____ . Any Rx Changes? Y or N

Low Back Pain Questions

YES NO

- ☐ ☐ Does Pain Radiate to the Abdomen and/or Groin?
- ☐ ☐ Any Impairment of Bowel or Bladder Function?
  - ♦Explain? _____
- ☐ ☐ Was There a Feeling of Ripping or Tearing?
- ☐ ☐ Do You Try to "Crack" Your Own Back?

Past Medical History

☐ Never ☐ 1-3 Times ☐ 4 or More Times: How Many Times Have You Had the Condition That You Are Seeing Us for Today?

YES NO

☐ ☐ **Do You Suffer From Any Other Health Condition(s)?** (Check All That Apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer
☐ Arthritis ☐ Infertility Issues ☐ Others: _____

☐ ☐ **Have You Ever Seen a Chiropractor Before?**

♦ When Was the Last Time You Were Seen? _____ Which Dr.? _____

♦ For What Problem(s)? _____ Were You Helped? _____

♦ How Often Were You Being Seen? _____ Why Did You Leave? _____

♦ List Any Other Chiropractors You've Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

☐ ☐ **Have You Ever Seen a Medical Doctor for This Condition Before?** (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

☐ ☐ **Do You Have Any Allergies?** If So, to What? _____

☐ ☐ **List Any Prescription Drugs, Over the Counter Drugs, Vitamins, and/or Supplements:** (Use More Paper as needed.)

Product / Drug	Reason(s)	Frequency	Dosage	Helping?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

☐ ☐ **Have You Attempted Any Other Self Care Remedies to Alleviate Your Condition? (e.g. topical ointments or Home Medical Equipment such as braces/supports, Cervical Pillow, Low Back Support Belt, Stretching, Exercising, etc.) If Yes, What?**

_____

☐ ☐ **Describe Any Major Illnesses, Injuries, Falls, Hospitalizations, Auto Accidents, and/or Surgeries:** (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

Social Health History

Gender: ☐ Male ☐ Female Student: ☐ Part-Time ☐ Full-Time ☐ School: _____

Occupation: _____ Hrs Per Week : _____ Yrs on Job: _____ Yrs with Employer: _____

Recreational Activities / Hobbies: _____

YES	NO	
☐	☐	Do You Exercise? How Often? _____ In What Way? _____
☐	☐	Are You a Smoker? How Much? _____
		How Much Water Do You Drink? _____
☐	☐	Do You Consume Caffeine? How Much & How Often? _____
☐	☐	Do You Consume Alcohol? How Much & How Often? _____

Family Health History

List Any Current or Past Health Conditions of Your Family Members. Or if Deceased, at What Age and From What?

Mother: _____

Father: _____

Brothers/Sisters: _____ How Many? _____

Children: _____ How Many? _____

System Review Questions

Have You Had Any Problems with the Following Areas Now or in the Past? (Please Mark **Y** for Yes or **N** for No in Each of the Following:)

1. ____ **Eyes** (glasses, contacts, cataracts, glaucoma, etc.)
2. ____ **Ears, Mouth, Nose, Throat** (hearing loss, sinus, etc.)
3. ____ **Cardiovascular** (heart, high b.p., high cholesterol, etc.)
4. ____ **Respiratory** (lungs, breathing, asthma, c.o.p.d., etc.)
5. ____ **Neurological** (nerve issues, weakness, numbness, etc.)
6. ____ **Endocrine** (thyroid, hormonal imbalances, liver, etc.)
7. ____ **Gastro-Intestinal** (acid reflux, ulcers, gall bladder, i.b.s., etc.)
8. ____ **Genito-Urinary** (male/female reproduction, kidneys, bladder, etc.)
9. ____ **Musculoskeletal** (breaks, arthritis, osteoporosis, discs, etc.)
10. ____ **Skin** (rashes, skin cancer, dryness, psoriasis, eczema, hair, etc.)
11. ____ **Psychiatric** (anxiety, depression, bipolar, add/adhd, etc.)
12. ____ **Others**: _____

Please Describe in More Detail: _____

Notes:

My signature is an acknowledgement that all 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 care, and I give authority for these procedures to be performed.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

D.C. Signature: _____ Date: _____

For Office Use Only

- ♦ **Level of History of Present Illness / Injury:** ☐ Brief ☐ Extended
- ♦ **Nature of Presenting Problem:** ☐ Minimal ☐ Self Limited ☐ Low Severity ☐ Moderate Severity ☐ High Severity
- ♦ **Level of Past Medical / Social / Family History:** ☐ N/A ☐ Pertinent (1 of above histories) ☐ Complete (2 or 3 of above histories)
- ♦ **Level of System Review:** ☐ Problem Pertinent (1system) ☐ Extended (2 9 above systems) ☐ Complete (10+ Above Systems)
- ♦ **Level of Overall History:** ☐ Problem Focused ☐ Expanded Problem Focused ☐ Detailed ☐ Comprehensive

INFORMED CONSENT

CHIROPRACTIC, AS WELL AS OTHER TYPES OF HEALTH CARE, IS ASSOCIATED WITH POTENTIAL RISKS IN THE DELIVERY OF TREATMENT. THEREFORE, IT IS NECESSARY TO INFORM THE PATIENT OF SUCH RISKS PRIOR TO INITIATING CARE. WHILE CHIROPRACTIC TREATMENT IS REMARKABLY SAFE, YOU NEED TO BE INFORMED ABOUT THE POTENTIAL RISKS RELATED TO YOUR CARE TO ALLOW YOU TO BE FULLY INFORMED IN CONSENTING TO TREATMENT.

CHIROPRACTIC OFFICES USE TRAINED STAFF PERSONNEL TO ASSIST WITH PORTIONS OF YOUR CONSULTATION, EXAMINATION, X-RAYS, PHYSICAL THERAPY APPLICATIONS, EXERCISE INSTRUCTIONS, ETC. OCCASIONALLY, WHEN YOUR CHIROPRACTOR IS UNAVAILABLE, ANOTHER QUALIFIED DOCTOR OF CHIROPRACTIC MAY TREAT YOU.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE – STROKE IS THE MOST SERIOUS POTENTIAL COMPLICATION OF CHIROPRACTIC TREATMENT. IT IS, ON RARE OCCASIONS, DUE TO INJURY OF THE VERTEBRAL ARTERY CAUSED BY CERVICAL SPINE ADJUSTMENT OR MANIPULATION, AND WHEN IT OCCURS, IT MAY CAUSE TEMPORARY OR PERMANENT BRAIN DYSFUNCTION. ON EXTREMELY RARE OCCASIONS, DEATH OCCURS. BECAUSE THE VERTEBRAL ARTERIES, WHICH SUPPLY THE BRAIN WITH BLOOD, ARE LOCATED WITHIN THE BONES OF THE CERVICAL SPINE, CERVICAL TREATMENT POSES A SMALL RISK. THE CHANCES OF THIS OCCURRING ARE ESTIMATED AT BETWEEN 1 PER 400,000 TREATMENTS TO 1 PER 5.8 MILLION TREATMENTS. USING DATA FROM TWO OF THE LARGEST CHIROPRACTIC INSURERS, THE RISK OF SERIOUS ARTERIAL STROKE SYNDROMES IS SHOW TO BE LESS THAN 1 IN 2 MILLION TO 1 IN 3.8-5.8 MILLION CERVICAL MANIPULATIONS. THE MOST COMMON TYPE OF VASCULAR LESION WITH THIS ASSOCIATION IS A DISSECTION OF THE VERTEBRAL ARTERY (VBA). (*CURRENT CONCEPTS: SPINAL MANIPULATION AND CERVICAL ARTERIAL INCIDENTS, 2005.)* **A 2008 STUDY IN SPINE JOURNAL STATES: "WE FOUND NO EVIDENCE OF EXCESS RISK OF VBA STROKE ASSOCIATED WITH CHIROPRACTIC CARE COMPARED TO PRIMARY CARE." THEREFORE THE RISK IS THE SAME NO MATTER WHOM YOU CHOOSE TO SEE.**

SORENESS – CHIROPRACTIC ADJUSTMENTS AND PHYSICAL THERAPY PROCEDURES ARE SOMETIMES ACCOMPANIED BY POST-TREATMENT SORENESS. THIS IS A NORMAL AND ACCEPTABLE ACCOMPANYING RESPONSE TO CHIROPRACTIC CARE. WHILE IT IS GENERALLY NOT DANGEROUS, PLEASE ADVISE YOUR DOCTOR OF CHIROPRACTIC IF YOU EXPERIENCE SORENESS OR DISCOMFORT.

SOFT TISSUE INJURY – OCCASIONALLY CHIROPRACTIC TREATMENT MAY AGGRAVATE A DISC INJURY, OR CAUSE OTHER MINOR JOINT, LIGAMENT, TENDON, OR OTHER SOFT TISSUE INJURY.

RIB INJURY – MANUAL ADJUSTMENTS TO THE THORACIC SPINE, IN RARE CASES, MAY CAUSE RIB INJURY OR FRACTURE. PRECAUTIONS SUCH AS TAKING PRE-ADJUSTMENT X-RAYS ARE TAKEN FOR CASES DEEMED "AT-RISK." TREATMENT IS PERFORMED CAREFULLY AND GENTLY TO MINIMIZE SUCH RISK.

PHYSICAL THERAPY BURNS – HEAT GENERATED BY PHYSICAL THERAPY MODALITIES MAY CAUSE MINOR BURNS TO THE SKIN. THESE ARE RARE, BUT SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC OR STAFF IF THEY OCCUR.

OTHER PROBLEMS – THERE ARE OCCASIONALLY OTHER TYPES OF SIDE EFFECTS ASSOCIATED WITH CHIROPRACTIC CARE. WHILE THESE ARE INDEED RARE, THEY SHOULD BE REPORTED TO YOUR DOCTOR OF CHIROPRACTIC PROMPTLY.

CHIROPRACTIC IS A SYSTEM OF HEALTH CARE DELIVERY AND THEREFORE, AS WITH ANY HEALTH CARE DELIVERY SYSTEM, WE CANNOT PROMISE A CURE FOR ANY SYMPTOM, CONDITION, OR DISEASE AS A RESULT OF TREATMENT IN THIS OFFICE. AN ATTEMPT TO PROVIDE THE VERY BEST CARE IS OUR GOAL AND IF THE RESULTS ARE NOT ACCEPTABLE, WE WILL REFER YOU TO ANOTHER PROVIDER WHO WE FEEL WILL BEST ASSIST YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS CONCERNING THE ABOVE, PLEASE ASK YOUR DOCTOR OF CHIROPRACTIC. WHEN YOU HAVE FULL UNDERSTANDING AND CONSENT TO HAVE CARE PROVIDED, PLEASE PRINT YOUR NAME AND SIGN AND DATE BELOW.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

PATIENT'S NAME PRINTED

TODAY'S DATE

PATIENT'S SIGNATURE

PARENT OR GUARDIAN'S SIGNATURE FOR MINOR