

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____

Birth Date: _____ Age: _____

Address: _____

Sex: Male / Female

City _____ State: _____ Zip: _____

Home Phone: _____

Social Security #: _____

Cell Phone: _____

Driver's License #: _____

E-mail Address: _____

Business Employer: _____

Fax #: _____

Occupation: _____

Business Phone: _____

Name of Spouse: _____

Spouse's Employer: _____

Type of Work: _____

Names & Ages of Children: _____

Referred To This Office By: _____

Relationship: _____

Name & Number of Emergency Contact: _____

Who is Responsible for your bill, you and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Personal Health Insurance Carrier: _____

Health Card ID #: _____

Insured Person's Name: _____

Group #: _____

Insured Person's Date of Birth: _____

Have You Had Previous Chiropractic Care? _____

Insured Person's Social Security #: _____

Name of Previous Chiropractor: _____

Amount of Time Under Care of a Chiropractor?

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition: Auto Related Work Related Other No Injury

Explain: _____

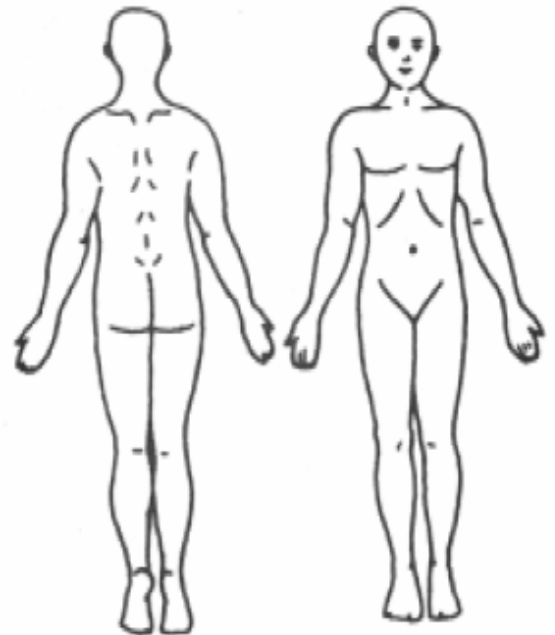
Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work: Have you filed an injury report with your employer? Yes No

Claim #: _____



Social History Questionnaire

OCCUPATION

Job Title: _____ **Work Hours Per Day:** _____

Max Lifting Req't: Sed(<5 lbs) Light (5-20 lbs) Med (20-50lbs) Hvy (>50 lbs)

Lifting Frequency: Constant (66-100%of day) Frequent (33-66% of day) Occasional (0-33% of day)

Lifting Postures: Knee Torso Arm Shoulder Off Posture

Work Activity Postures:

Sitting: _____ Hrs per day Standing: _____ Hours per day Walking: _____ Hrs per day

Climbing: _____ Hrs per day Pushing: _____ Hours per day Pulling: _____ Hrs per day

Kneeling: _____ Hrs per day Reaching: _____ Hours per day Twisting: _____ Hrs per day

Repetitive Activities:

Computer: _____ Hrs per day Phone: _____ Hours per day Machinery: _____ Hrs per day

Hand Tools: _____ Hrs per day Assembly: _____ Hours per day Grasping: _____ Hrs per day

Other: _____ Hrs per day

Impact of Current Condition on Work Capacity: No Effect Painful Limits Unable

Recreational Activity Performance

Effect of Current Condition on

_____	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
_____	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
_____	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
_____	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
_____	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>

Daily Activities Performance

Effect of Current Condition on

Washing/Bathing	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Household Chores				
Sweeping/Vacuuming	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Dishes	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Laundry	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Yard work	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Garbage	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Other: _____	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Climbing Steps	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Lifting Groceries	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Dressing	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Sleep	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Driving	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Concentration (Reading)	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>
Sexual Activity	No Effect <input type="checkbox"/>	Painful <input type="checkbox"/>	Limits <input type="checkbox"/>	Unable <input type="checkbox"/>

Signature

Date

Please list all drugs you are taking (including prescription, non-prescription drugs, such as birth control, aspirin, heart medication, laxatives, cold tablets, allergy medication)

Medication _____ Purpose _____
 Medication _____ Purpose _____
 Medication _____ Purpose _____
 Medication _____ Purpose _____

Health History:

Please indicate which of the conditions below you have experienced. Mark all that you have had in the past 6 months with a check mark.

- Acid Reflux Diabetes Nervousnes ADD/ADHD
- Dislocated Joints Numbness Aids Dizziness
- Polio Anemia Ear Infection Poor Circulation
- Asthma Epilepsy Reproductive Trouble Back Pain
- German Measles Rheumatic Fever Bladder Headaches/Migraines
- Rheumatism Bone Fracture Heart Trouble Scarlet Fever
- Bowel Control Loss Hepatitis Serious Injury Bronchitis
- High Blood Pressure Sinus Trouble Carpal Tunnel Indigestion
- Tired/Fatigued Cancer Kidney Disorder Tuberculosis
- Chest Pain Menstrual Cramps V.D. Concussion
- Multiple Sclerosis Cramping Multiple Dystrophy
- Depression Neck Pain

Has either of your parents experienced any of the above conditions? _____

Lifestyle Information:

How would you describe your:

Diet Poor Good Excellent
 Rest Poor Good Excellent
 Exercise Poor Good Excellent

Stress (Scale of 1-10, 10 being the most stressful) Occupational Stress _____

Personal Life _____

Do you take any Vitamins or Herbs? Yes No

Are you a member of a health club? Yes No

Do you buy bottled water? Yes No

ADDITIONAL PATIENT HISTORY ON SUBLUXATION

Our patients have had literally dozens of impacts that could cause subluxations. I want to discover several of yours.

1. When was your most recent auto accident? _____
 - a. Speed: _____
 - b. Front, side, or rear-end collision? _____
 - c. Was treatment received? YES / NO If yes, where?

2. When was your most recent stress or strain at work? _____
 - a. Was any treatment needed? YES / NO
 - b. When was the one before that? _____
 - c. What type of jobs have you done? _____

3. What sport or recreational activities do you do? _____
 - a. When was your most recent stress or strain during your activity?

 - b. Was any treatment received? YES / NO
 - c. When was the one before that? _____

4. Is there any other injury to your spine, minor or major, that the doctor should know about?

- Vertebral Subluxations can cause pain -

1. Which pain or condition have you marked the worse? _____

2. How long has it bothered you? _____

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Are your pains sharp or dull? _____

4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Which do you feel? _____

5. Pressure on the spinal cord or nerves can be worse in the AM or PM. Which is worse for you? _____

6. Does this pain radiate into an extremity or stay in one area?
