CONFIDENTIAL PATIENT RECORD

Referred By:

Date: File No.:

PERSONAL HISTORY

Name:
Address:
City:
State/Prov.: Zip Code:
Birth Date: Age: Sex: m / f
Social Security #:
Driver's License #:
Circle One: Married Single Widowed Divorced Separated
Employer:
Type of Work:

Home Phone:
Cell Phone:
Business Phone:
E-mail:
Name of Spouse:
Spouse Employer:
Type of Work:
Spouse's Phone:
Names & Ages of Children:

Name & Number of Emergency Contact: Relationship:

WELLNESS AND EARLY DETECTION TESTING

If you have an interest in achieving your personal OPTIMUM HEALTH POTENTIAL through wellness practices and early detection, please **check this box** ☐

YOUR HEALTH PROFILE

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES / NO / UNSURE				YES / NO /UNSURE		
Did you have any childhood illnesses?	□	□	□	Were you involved in any car accidents as a child?	□	□	□
Did you have any serious falls?	□	□	□	Was there any prolonged use of medicine such as			
Did you play youth sports?	□	□	□	antibiotics, and/or an inhaler?	□	□	□
Did you take/use any drugs?	□	□	□	Did you suffer any other traumas?	□	□	□
Did you have any surgery?	□	□	□	(physical or emotional)			
Have you fallen/jumped from a height over				Were you vaccinated?	□	□	□
Three feet? (i.e. crib, bunk bed, tree)	□	□	□	Were you under chiropractic care?	□	□	□

Comments:

YOUR ADULT YEARS (18 – present)

	YES / NO / UNSURE				YES / NO / UNSURE		
Do/did you smoke?	□	□	□	Do/did you play any adult sports?	□	□	□
Do/did you drink alcohol?	□	□	□	Do/did you participate in extreme sports?	□	□	□
Have you been in any accidents?	□	□	□	On a scale of 1-10 (10 being highest)			
Have you had any surgeries?	□	□	□	Describe your stress level:			
				Occupational: _____			
				Personal: _____			

On a scale of POOR, GOOD, or EXCELLENT, describe your:

Diet: _____ Exercise: _____ General Health: _____ Sleep: _____

IF YOU CURRENTLY HAVE A HEALTH CONDITION

MAJOR HEALTH COMPLAINT(S): _____

_____

How long have you had this/these condition(s)? _____

Date your condition began? _____ Have you lost workdays? Yes ( ) No ( ) How many? _____

Have you had a similar condition before? Yes ( ) No ( ) When? _____

Was the injury related to: work accident ( ) auto accident ( )

When did you see your last chiropractor? _____ Doctor: _____

Why did you see this chiropractor? _____ Were you helped? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

_____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

PLEASE CHECK WHERE YOUR BODY HAS NOT FUNCTIONED PROPERLY IN THE LAST SIX MONTHS:

A: MUSCULO-SKELETAL MALFUNCTION

- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/Stiffness
- □ Walking Difficulties
- □ Difficult Chewing/Clicking Jaw
- □ General Stiffness
- □ Numbness
- □ Paralysis
- □ Cold/Tingling Extremities

B. ORGAN AND GLAND MALFUNCTION

- □ Nervous
- □ Dizziness
- □ Forgetfulness
- □ Confusion/Depression
- □ Fainting
- □ Convulsions
- □ Fatigue
- □ Allergies
- □ Loss of Sleep
- □ Fever
- □ Headaches
- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Hemorrhoids
- □ Liver Problems
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas/Bloating After Meals
- □ Heartburn
- □ Colitis
- □ Bladder Trouble
- □ Painful/Excessive Urination
- □ Chest Pain
- □ Short Breath
- □ Blood Pressure Problems
- □ Irregular Heartbeat
- □ Heart Problems
- □ Lung Problems/Congestion
- □ Ankle Swelling
- □ Stroke
- □ Sore Throat
- □ Ear Aches
- □ Hearing Difficulty
- □ Menstrual Irregularity
- □ Vaginal Pain/Infection
- □ Breast Pain/ Lumps
- □ Prostate/Sexual Dysfunction
- □ Other Problems: _____

FAMILY HEALTH PROFILE:

At our office, we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother/Sister: _____

Other: _____

What is your health philosophy? (What should you do to be healthy?)

List drugs you now take (prescription and non-prescription): _____

List all vitamins and supplements you now take: _____

Name other doctors you have seen for this condition: _____

What was done and for how long? _____

How do you want us to handle your problem?

_____ Temporary Relief (Help the symptom, but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Why did you come into our clinic and what are your expectations of us?

1. What are your favorite hobbies or activities to do now? _____
2. Are your current problems affecting these activities or hobbies? _____
3. What activities are your looking forward to doing in retirement? _____
4. Who would you like to be doing these with? _____

On a scale of 1-10 (10 being the most):

_____ How committed are you to being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

Comments: _____

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 collecting from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that, If I suspend or terminate, and fees for professional services will be immediately due and payable.

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate. I understand and agree that the amount paid for x-rays is for their examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at anytime while I am a patient of this office. I also agree that I am responsible for all bills they incurred by me at this office.

Patient Signature: _____ Date: _____

Consent to treat a minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____