Confidential Patient Health Record

Name:_____ **Date:** _____/_____/_____

Current Age:_____ **Gender**: ☐ Male ☐ Female **Hand Dominance**: ☐ Right ☐ Left

Health History

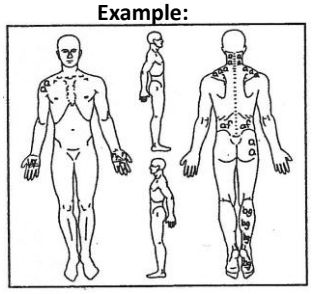
Please describe the reason for your visit: _____
How long have you had this problem? _____
Have you had this problem before? ☐ Yes ☐ No If Yes, when? _____ How many times? _____
What do you think caused this problem? _____
Have you ever seen a chiropractor? ☐ Yes ☐ No If Yes, when were you last treated? _____

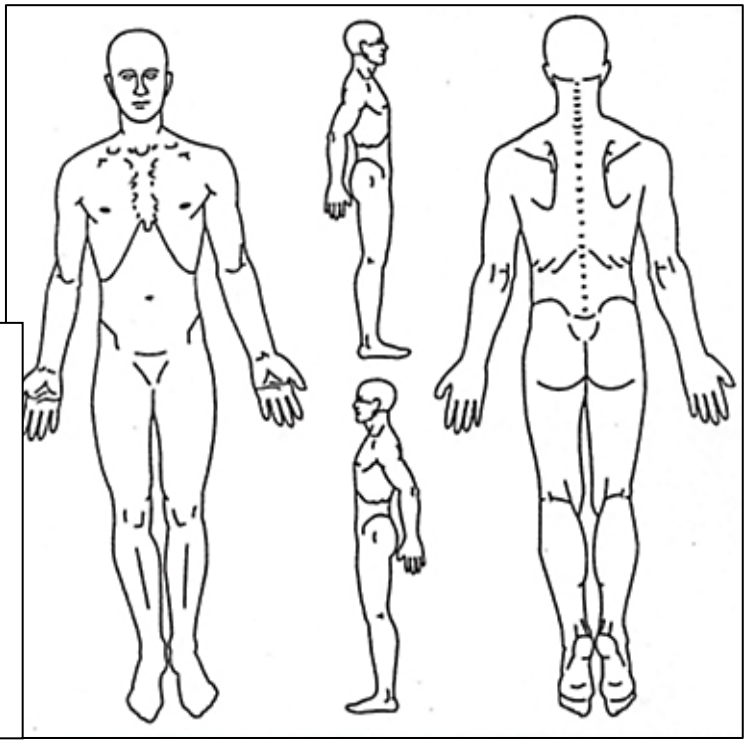
Symptom Map

Report here the symptoms you feel at the present time. Mark the body area(s) with the type of symptoms, using the symbols in the key below. Then please list the additional information in the chart below.

Symptom Symbols
Aching = a
Burning = b
Numbness = n
Sharp = s
Stiffness = f
Tingling = g
Weakness = w

Example:





What helps to relieve your symptoms? (Check one or more)
☐ Chiropractic ☐ Ice ☐ Heat ☐ Massage
☐ Medication ☐ Resting ☐ Sitting ☐ Sleeping
☐ Standing ☐ Stretching ☐ Lying Down ☐ Nothing
☐ Other_____

What activities are limited by your symptoms?
(Check each and note how many minutes before discomfort)
☐ Standing_____ ☐ Sitting_____ ☐ Lying_____
☐ Sleeping_____ ☐ Lifting_____ ☐ Desk Work_____
☐ Walking_____ ☐ Running_____ ☐ Working out_____
☐ Movement_____ ☐ Bending_____ ☐ Housework_____

Region	**Side** Left Side (L) Right Side (R) or Both (B)	**Pain Type** Aching (a), Burning (b), Numbness (n), Sharp (s), Stiff (f), Tingling (g), Weakness (w)	**Pain Rating** Choose 0 (no pain) to 10 (intolerable pain)	**Pain Frequency** Constantly (C) (76-100% of the time) Frequently (F) (51-75% of the time) Occasionally (O) (26-50% of the time) Intermittently (I) (1-25% of the time)
Example: Low Back	**L**	**a, b**	**8**	**C**

Previous Examination and Treatment *(For This Complaint Only)*

Place a "**C**" next to all symptoms/problems you have currently
and place a "**P**" next to all symptoms/problems you have had in the past

___Tingling or numbness into the shoulders, arms or hands (upper extremities)
___Tingling, or numbness into the hips, legs, or feet (lower extremities)
___Recent loss or blurring of vision
___Cancer:
Type(s):_____
Date diagnosed: ___/____/____
___Diabetes:
___Type I
___Type II (adult onset)
___Condition aggravated by coughing or sneezing
___Loss of sexual function
___Recent onset of:
___Urinary retention
___Increased urinary frequency
___Inability to control bladder
___Constant pain unrelated to movement
___Night pain unrelated to movement
___Unexplained weight loss greater than 10 lbs.
___History of malaise/generalized weakness
___History of fever or chills
___Osteoporosis
___Bacterial Infection
Date it began____/____/_____
___Abdominal pain
___Blood in urine
___Rectal bleeding
___Urethral discharge
___Prolonged steroid use
___IV drug abuse

____ Allergies
Type: _____
_____
____ Anxiety/Panic attacks
____ Angina
____ Alcoholism
____ Anemia
____ Anorexia
____ Appendicitis
____ Arteriosclerosis
____ Arthritis
____ Asthma
____ Auto-Immune Disorder
____ Back pain
____ Bleeding disorders
____ Blindness
____ Blurred Vision
____ Bulimia
____ Bursitis
____ Bronchitis
____ Bruise easily
____ Cataracts
____ Chemical dependency
____ Chest pain
____ Chicken Pox
____ Chronic back problems
____ Chronic lung disease
____ Bronchitis
____ Emphysema
____ Connective tissue disease
Type:_____
Date diagnosed:
_____/_____/_____
____ Cold feet or hands
____ Congestive Heart Failure
____ Constipation
____ Deafness or reduced hearing
____ Depression
____ Dermatitis
____Digestive problems
____ Diarrhea
____ Dizziness
____ Drug/alcohol dependency
____ Epilepsy
____ Fainting
____ Fatigue
____ Fibromyalgia
____ Fractures
____ Gall Bladder Problems
____ Glaucoma
____ Goiter
____ Gout
____ Hair loss
____Headaches
____ Heart attacks
____ Heart Disease
____ Hepatitis
____ Hernia
____ Herniated disc
____ Herpes
____ High Blood Pressure
____ High Cholesterol
____ HIV/AIDS
____ Hives
____ Hormone replacement
____ Hot flashes
____ Hypertension
____ Impaired Hearing
____ Indigestion/Heartburn
____ Irregular Heart Beat
____ Irregular Menstrual Cycle
____ Jaw problems
____ Joint swelling
____ Kidney Disease
____Kidney stones
____ Liver Disease
____ Loss of smell
____ Loss of memory
____ Loss of taste
____ Low Blood Pressure
____ Low Blood Sugar
____ Measles
____ Menopause
____Menstrual cramps
____ Migraines
____ Miscarriage
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Muscular incoordination
____ Nausea
____ Nervousness
____ Pacemaker
____ Painful urination
____ Parkinson's Disease
____Pinched nerve
____PMS
____ Pneumonia
____ Polio
____ Pregnancy
____ Prostate Disease
____ Prostate problems
____ Prosthesis
____ Psychiatric Care
____ Psoriasis
____ Rash
____ Rheumatic fever
____ Rheumatoid arthritis
____ Ringing/buzzing in the ears
____ Scarlet fever
____ Sciatica
____ Scoliosis
____ Shortness of breath
____ Sinus problems
____ SLE (lupus)
____ Sleeping difficulties
____ Sore Throat
____ Spinal Disc Disorder
____ STDs (venereal, etc.)
____ Stomach problems
____ Stroke
____ Swelling of ankles or feet
____ Tendonitis
____ Tension
____ Thyroid Disorder
____ Tumor(s)
____ Ulcer/gastrointestinal bleeding
____ Unexplained excessive thirst
____ Unexplained loss of appetite
____ Vaginal infections
____ Visual disturbances
____ Whooping cough

Please tell us about any hospitalizations, traumas (falls/auto accidents/ broken bones), serious illnesses or surgeries:

Year	Reason	Hospital	Outcome/Residual Problems

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Product	Reason	Dosage (Ex. 500 mg)	Frequency (Ex. 2x/day)	Is it helping?	How Long?
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Please provide details of any known allergies. (eg. Latex, medications, foods)

Allergy	Reaction

Health Habits

How is most of your day spent? ☐ **Sitting- #hrs:_____** ☐ **Standing- #hrs:_____** ☐ **Other:_____**

Exercise:

How often to you exercise? ☐ Never ☐ Rarely ☐ Occasionally ☐ Moderately ☐ Regularly

Type of exercise: _____

If you exercise, what is the intensity? ☐ Light ☐ Moderate ☐ Strenuous

Interests/Hobbies:

What interests, hobbies or activities do you enjoy? _____

Habits:

Do you drink alcohol? ☐ Never ☐ Once a week ☐ Several times a week ☐ Once daily ☐ Several times per day

Tobacco Use:

Cigarettes: ☐ Never ☐ Used in the past ☐ Less than ½ pack/day ☐ ½ pack/day ☐ 1 pack/day ☐ more_____

Chewing Tobacco: ☐ Never ☐ Used in the past ☐ Occasionally ☐ Often

Cigars: ☐ Never ☐ Used in the past ☐ Occasionally ☐ Often

For how many years have you used tobacco products? _____

If you have quit smoking, when did you quit? _____ **months ago / years ago** (please circle one)

Diet /Nutrition:

Are you dieting currently? ☐ Yes ☐ No **Is this a physician prescribed medical diet?** ☐ Yes ☐ No

How many meals do you eat on average every day? _____

Do you drink water daily? ☐ 0-2 glasses ☐ 2-4 glasses ☐ 4-6 glasses ☐ 6-8 glasses ☐ 8-10 glasses

Do you drink things with caffeine? ☐ Never ☐ Once a week ☐ Few times/week ☐ Once daily ☐ Several times/day

Do you eat refined sugar? ☐ Never ☐ Once a week ☐ Few times/week ☐ Once daily ☐ Several times/day

Do you consume dairy products? ☐ Never ☐ Once a week ☐ Few times/week ☐ Once daily ☐ Several times/day

Do you eat wheat products? ☐ Never ☐ Once a week ☐ Few times/week ☐ Once daily ☐ Several times per day

Sleep Patterns:

Does your complaint disrupt your sleep? ☐ Yes ☐ No

How many hours do you sleep? ☐ 1-3 hours ☐ 3-5 hours ☐ 6 hours ☐ 7 hours ☐ 8 hours ☐ More than 8 hours

How would you rate your sleep quality? *Terrible* 1 2 3 4 5 6 7 8 9 10 *Great*

What position do you sleep in? _____

Do you sleep with a pillow? ☐ Yes ☐ No If yes, how many? _____

Stress Factors:

How would you rate your daily stress level? *None* 1 2 3 4 5 6 7 8 9 10 *Terrible*

Please rate your stress management strategies: *None/Poor* 1 2 3 4 5 6 7 8 9 10 *Great*

Please Rate your overall energy levels: *Low* /Poor 1 2 3 4 5 6 7 8 9 10 *High/Excellent*

Pregnancy/ Children: # of Children _____ # of C-sections_____

Family History:

If any parents, grandparents or siblings have/had any of the following, please check and indicate which relative(s):

☐ **Alcoholism**	☐ **Cancer**	☐ **High Blood Pressure**
☐ **Anemia**	☐ **Diabetes**	☐ **High Cholesterol**
☐ **Arteriosclerosis**	☐ **Emphysema**	☐ **Multiple Sclerosis**
☐ **Arthritis**	☐ **Epilepsy**	☐ **Osteoporosis**
☐ **Asthma**	☐ **Glaucoma**	☐ **Stroke**
☐ **Auto Immune Disorder**	☐ **Heart Disease**	☐ **Thyroid Disease**
☐ **Bleeds easily**		☐ **Other_____**

Medical Status:

Last Physical Exam? _____ Last Urine and/or Blood work? _____ Any abnormal findings? ☐ Yes ☐ No

If YES, please explain: _____

Are you currently under medical care for ANY reason? ☐ Yes ☐ No If YES, please explain _____

_____

Please list any other illnesses, significant conditions or concerns regarding your health of which the doctor should be aware. *(List for each if it is a current or past condition)*:_____

_____

_____

Work Status

Work schedule: ☐ Full Time ☐ Part Time **Hours per day: ____ Typical overtime hours: _____ Average hours per week: ____**

Has the condition caused you to miss work? ☐ Yes ☐ No **(If "No" please skip this section)**

Date you were first off work ____/_____/_____

Returned to work? ☐ Yes ☐ Limited hours only ☐ No **Date of return** _____/_____/____

(Ex: MD, chiropractic physician, neurologist)

Returned to work with recommendation from_____ ☐ **Returned without recommendation**

Can you perform your usual work duties? ☐ Yes ☐ No **Is alternative work available to you?** ☐ Yes ☐ No

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Has a physician placed you on work restriction/disability? (If No, please skip this section)

☐ Yes, **TOTAL** restriction/disability ☐ Yes, **PARTIAL** restriction ☐ No

By whom? (List doctor's name and specialty) _____

Please list your work restrictions: _____

Expected return to regular work duties: ____/_____/_____ ☐ Date for return to regular work is unknown.

Consent to X-Ray Examination

I have been told and understand that consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze my spinal condition. I confirm that the office has hereby advised me that x-rays can be hazardous to an unborn child. I admit that the following accurately states my current condition:

- ☐ There IS a possibility that I may be pregnant at this time
- ☐ YES, I am definitely pregnant and do not consent to x-rays at this time.
- ☐ NO, I am definitely NOT pregnant at this time

☐ **I consent to having radiographic (x-ray) films taken if necessary**

_____

Patient/Guardian Signature: _____ Date: _____/_____/_____

****

I understand that the information contained within this form is confidential. I certify that this form was completed correctly and to the best of my knowledge.

Patient/Guardian Signature: _____ Date: ___/____/____