PATIENT HEALTH RECORD

Name: ______________________________ What do you prefer to be called? __________________________

Hm Phone: _________________________ Wk ________________________ Cell _______________________

May we send you texts? (Appt. reminders, etc.) Yes ❑ No ❑

Address: ___________________________________ City:____________________ St: _________ Zip:_________

Date of Birth: _________ Marital Status (circle one) M S D W Age_________

Driver's License: ___________________State ____ E-mail Address __________________________________

Occupation: ________________________________ Employer:____

Work Address: ____ City, St, Zip: _________________________

Spouse/Significant Other's Name: _______________________________________ # of Children: ____________

Whom may we thank for referring you? ____

Have you ever had Chiropractic care before? Yes ❑ No ❑ Date: _______________

What Brought You Into This Office? Specific complaint ❑ Wellness check up ❑

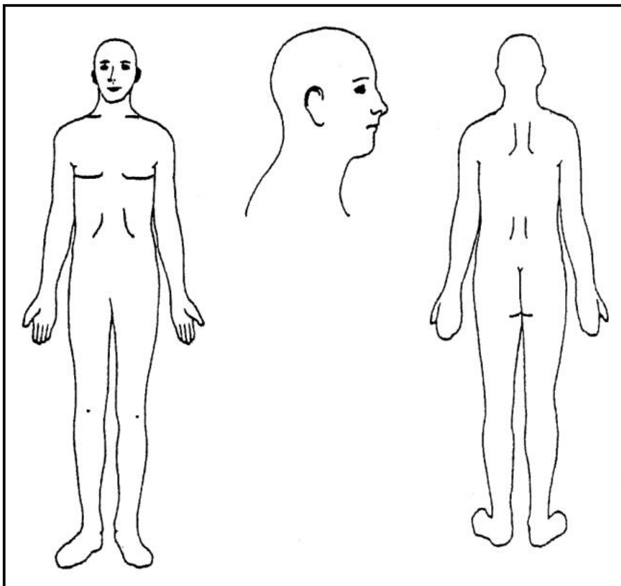
*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Current Health Concerns

Please list your health concerns according to their severity	Rate severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

PLEASE MARK ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE LOCATED;

P = SHARP PAIN
T = TIGHTNESS
W= WEAKNESS
A = ACHE
N = NUMBNESS



Is your pain dull? Sharp? Does it radiate anywhere? If so, where?

____

Since the problem started is it; About the same? ❑ Getting better? ❑ Getting worse? ❑

What have you done for this condition? Was it of benefit?

____

____

I do (do not) have a family history of this or similar symptoms

(Please explain): _________________________________

____

____

What activities aggravate your condition?

____

____

Official Use; V1 Gr Re As QuLi 3D Vi Sub TTAT xfs HPnBP Pg 4Q Sig
V2 P2O Re Sub Hp Sx-NePr xfs DeMod HPnBP Pg 1Con P2O Fin

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Do you feel you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what? _________________

____

Is this condition interfering with any of the following?
❑ Work ❑ Sleep ❑ Daily Routine ❑ Sports/exercise ❑ Other (Explain)_______________________

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us to help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had X-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ❑ No ❑

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription) ________________

____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:______________________________

____

Are you interested in knowing more about how the food you eat affects your overall health and well-being? ❑ Yes ❑ No ❑ Maybe
If dietary changes are indicated would you be willing to make changes in your diet? ❑ Yes ❑ No ❑ Maybe
Would you take whole food supplements if indicated? ❑ Yes ❑ No ❑ Maybe
If specific exercises or stretching would help would you consider adding them to your program? ❑ Yes ❑ No ❑ Maybe
If reducing stress would help you would you like to know ways to reduce stress? ❑ Yes ❑ No ❑ Maybe

Diet; Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M -** Consume this monthly | **O -** Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

Past Health History; Have you ever had any of the following diseases /health conditions?

❑Headaches, Frequent or Severe ❑High/ Low B.P. ❑Stroke or TIA ❑Ulcer/ Reflux/ Indigestion
❑Allergies/ Sinus Problems ❑Asthma/ Breathing Problems ❑Arthritis ❑IBS/ Crohn's/ Diarrhea or Const.
❑Neck/ Back Pain, Freq or Severe ❑Tuberculosis ❑Diabetes ❑Bladder Prob./ Bedwetting
❑Fainting/ Seizures/ Epilepsy ❑Emphysema ❑Kidney Problems ❑Menstrual Prob./ Infertility
❑Heart Attack/ Disease ❑Hepatitis/ Liver Problems ❑Herpes/ Shingles ❑Psychiatric Problem
❑Heart Surgery/ Pacemaker ❑Alcohol/ Drug Abuse ❑Anemia ❑Rheumatic Fever
❑Poor Circulation ❑Cancer/ Chemotherapy ❑Venereal Disease ❑Other ____________________

Stressors

Accumulation of stress affects our health and ability to heal. Please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ______________________________
   b. ______________________________
   c. ______________________________
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ______________________________
   b. ______________________________
   c. ______________________________
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ______________________________
   b. ______________________________
   c. ______________________________

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

_____ at Home _____ at Work _____ at Play

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

_____ Eating Habits _____ Exercise _____ Sleep _____ General Health _____ Mind Set

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you which has not yet been discussed? ____________________

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I consent to a professional, complete chiropractic examination and to any radiographic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ______________________________ Date: ____________________

Signature: ______________________________