

# PATIENT HEALTH RECORD

## ABOUT THE PATIENT

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Marital Status: M S D W Number of Children: \_\_\_\_\_  
Children's names and ages: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## ABOUT THE SPOUSE OR PARENT/EMERGENCY CONTACT

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Primary insured's date of birth: \_\_\_\_\_

## REASON FOR THIS VISIT

Describe the purpose of this visit: \_\_\_\_\_  
Is this visit related to: Job Sports Auto Chronic discomfort Fall  
Has the condition: Gotten worse Stayed constant Comes and goes  
Does this condition interfere with: Work Sleep Daily routine Sports  
Have you seen other doctors for this condition: Yes No

## EXPERIENCE WITH CHIROPRACTIC

Who referred you: \_\_\_\_\_  
Have you been adjusted by a Chiropractor before?: \_\_\_\_\_

## AWARENESS OF CHIROPRACTIC PRINCIPLES

WERE YOU AWARE THAT:

- Doctors of Chiropractic work with the nervous system?: Yes No
- The nervous system controls all bodily functions?: Yes No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?: Yes No

## MEDICATIONS I NOW TAKE

\_\_\_\_\_ Pain Killers \_\_\_\_\_ Muscle Relaxers \_\_\_\_\_ Blood Pressure Medication  
\_\_\_\_\_ Anti Depressants \_\_\_\_\_ Inhalers \_\_\_\_\_ Ibuprofen/Tylenol/Aspirin  
\_\_\_\_\_ Supplements Others: \_\_\_\_\_

## HEALTH HABITS

Do you smoke? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ packs/day  
Do you drink alcohol? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ drinks/day

Do you drink? \_\_\_\_\_ Reg. Soda \_\_\_\_\_ Diet Soda \_\_\_\_\_ Fruit Juice  
Do you exercise regularly? \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ times/week

## HEALTH CONDITIONS

(Please circle)

headaches	neck pain	lower back pain
sinus problems	dizziness	loss of sleep
pain between shoulders	digestive problems	ulcers/colitis
heart attack/stroke	congenital heart defect	heart murmur
high/low blood pressure	difficulty breathing	mid back pain
asthma	arthritis	alcohol/drug abuse
venereal disease	HIV/Aids	diabetes
shingles	kidney problems	hepatitis
cancer	anemia	thyroid problems
psychiatric problems	numbness/pain/tingling in arms/legs/hands	

## FOR WOMEN

Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No Do you take birth control? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Are you nursing? \_\_\_\_\_ Yes \_\_\_\_\_ No Are your cycles regular? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Do you have breast implants? \_\_\_\_\_ Yes \_\_\_\_\_ No

## GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh you needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- \_\_\_\_\_ **Relief Care**- Symptomatic relief of pain or discomfort.  
\_\_\_\_\_ **Corrective Care**- Correcting the cause while relieving the symptoms.  
\_\_\_\_\_ **Comprehensive Care**- Achieving the highest state of health possible.  
\_\_\_\_\_ **I want the Doctor to decide the type of the appropriate care for me**

## AUTHORIZATION FOR CARE

I HEREBY AUTHORIZE THE Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Date