PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name ____

Address ______________________________________

City _________________________ State _________

Zip ________________ Phone __________________

Birth date ___________

Cell Phone ______________ Carrier ____________

Age ___________ Gender _______ #Children _____

Employer _____________________________________

Marital Status ______ Work Phone______________

May we contact you at work? ◇ Yes ◇ No

Type of Work _________________________________

Social Security # _____________________________

E-mail address ________________________________

Contact via e-mail about appts.? ◇ Yes ◇ No

EMERGENCY CONTACT

Name ____

Relation _____________________________________

Home phone ___________________________________

Work phone ___________________________________

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ________________

Have you seen or heard about us in/on:

◇ Radio ◇ Clinic Sign ◇ Phone Book

Have you been adjusted by a Chiropractor before?

◇ Yes ◇ No

Reason for those visits _________________________

Doctor's name __________________________________

Approximate date of last visit ___________________

REASON FOR THIS VISIT

Describe the purpose of this visit ________________

____

Is the purpose of this appointment related to:

◇ Job ◇ Sports ◇ Auto ◇ Fall ◇ Other

◇ Home Injury ◇ Chronic Discomfort

Please explain ________________________________

____

____

When did this condition begin? __________________

Has this condition:

◇ Gotten Worse ◇ Stayed Constant

◇ Comes and Goes

Does this condition interfere with:

◇ Work ◇ Sleep ◇ Daily routine

◇ Other Activities

Please explain ________________________________

____

Has this condition occurred before? ______________

Please explain ________________________________

____

Have you seen other doctors for this condition?

◇ Yes ◇ No

Doctor's Name _________________________________

Type of treatment ______________________________

Results _______________________________________

HEALTH HABITS

	Yes	No
Do you smoke?	____	____
Do you drink alcohol?	____	____
Do you drink coffee, tea or soda?	____	____
Do you exercise regularly?	____	____

AWARENESS OF THE CHIROPRACTIC PRINCIPLES

Were you aware that:

Doctors of Chiropractic work with the nervous system?	◇ Yes	◇ No
The nervous system controls all bodily functions and systems?	◇ Yes	◇ No
Chiropractic is the largest natural healing profession in the world?	◇ 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 your 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

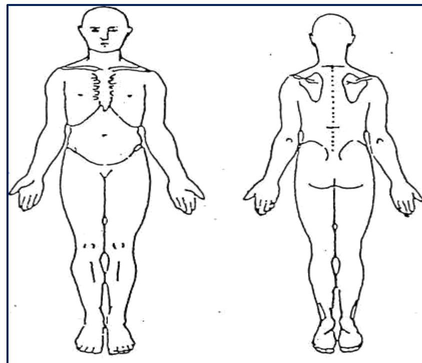
◇ Corrective care – Correcting and relieving the cause of the problem as well as the symptoms

◇ Comprehensive care – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

MEDICATIONS I NOW TAKE. . .

◇ Cholesterol medication
◇ Blood pressure medication
◇ Stimulants
◇ Blood thinners
◇ Tranquilizers
◇ Pain Killers (including aspirin)
◇ Muscle relaxers
◇ Other ____________________

"MARK" THE AREAS OF CONCERN



◇ Throbbing ◇ Stiffness
◇ Sharp ◇ Swelling
◇ Dull ◇ Burning
◇ Numbness
◇ Aching
◇ Tingling
◇ Cramping

HEALTH CONDITIONS

◇ Headaches
◇ Neck Pain
◇ Sleeping Problems
◇ Back Pain
◇ Neck Stiffness
◇ Pins & Needles – Legs
◇ Pins & Needles – Arms
◇ Numbness – Fingers

◇ Numbness – Toes
◇ Fatigue
◇ Ears Ring
◇ Feet Cold
◇ Hands Cold
◇ Heart attack/stoke
◇ Sinus Problems
◇ High/Low Blood Pressure

Women Only:

Are you pregnant? ◇ Yes ◇ No

Are you nursing? ◇ Yes ◇ No

Are you taking birth control?

◇ Yes ◇ No

Do you have irregular cycles?

◇ Yes ◇ No

◇ Other Conditions you are experiencing: ____

◇ Previous Surgeries & Major Injuries: ____