Confidential Patient Record

Name _____ Gender _____ Age _____ Birthdate _____ **Date** _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ Work _____ Fax _____

Email _____ Social Security _____ Name of Spouse _____

Occupation _____ Employer _____

Name of Emergency Contact _____ Contact's Phone Number _____

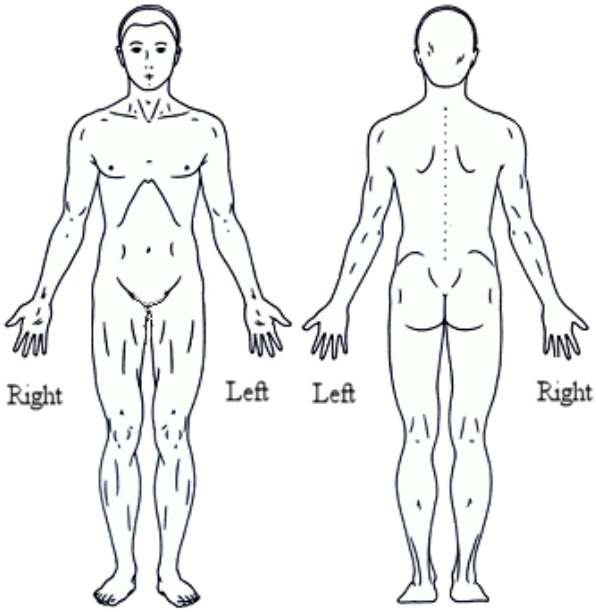
How did you hear about our office? _____

Have you ever been to a chiropractor before? **Y** / **N** If yes, which doctor? _____

Health Evaluation

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the right by circling the number that best represents your pain, where **0 is no pain** and **10 is pain as bad as you can imagine**. (If you are having pain in multiple locations circle multiple numbers, then indicate for which area each number represents.)

Using the symbols to the right, mark on the pictures where you feel pain or abnormal sensation.	Numbness	= = =	Dull Ache	OOO
	Burning	XXX	Sharp/Stabbing	/ / /
	Pins, Needles	+ + +	Other _____	^ ^ ^



Rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Rate your pain by circling the one number that best describes your pain at its BEST in the past 24 hours.

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Rate your pain by circling the number that best describes your pain on AVERAGE for the past WEEK.

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

***Note**: Please feel free to use the back page of this form if you need more room to explain any of your answers.*

Complaints Please rank your health complaints and rate their severity on a scale of 0-10 (10 being the worst pain imaginable). This could include you current pain, a chronic injury [ex. "bad" knee/shoulder], stress, general health, etc.

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Goals What are your goals for seeing Dr. Harris? _____

_____

Stress Level Rate your stress level currently on a scale from 0-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, not happy with life, depression, etc.

Overall Stress _____ Main reason for stress _____

If over level 5, what steps are you currently taking to reduce your stress? _____

Exercise Do you exercise? **Y N** How often? _____ How long per session? _____

What type of exercise do you do? _____

Smoking Do you currently smoke tobacco? **Y N** How often? _____ For how long? _____

Do you currently smoke marijuana? **Y N** How often? _____ For how long? _____

Daily Habits For each of these items listed below specify if you consume them and how often (i.e. 2 cups/day).

Coffee/Tea _____ Soda _____ Alcohol _____ Water _____ Fast Food _____

Vitamins/Minerals _____

Allergies Please list any known allergies, including food allergies, environmental, seasonal, drug, etc.

_____

Medical History Please describe any conditions which are currently under the care of a physician.

Diagnosis _____

Date of Onset _____ Duration of Current Symptoms _____

Doctor(s) involved, their specialty _____How diagnosed (what test)? _____

Current Treatment (medication, etc) _____

Treatment received in past, if any, and how it worked _____

Medications Please list any medications you are taking or have taken in the recent past. **Please include *name* and *dosage of medication***.

☐ Antacids	☐ Antihistamines	☐ Blood Pressure Med's	☐ Hormones	☐ Parasite Medication
☐ Antibiotics	☐ Anti-Inflammatory	☐ Cardiac/Heart Med's	☐ Muscle Relaxers	☐ Steroids
☐ Antidepressants	☐ Birth Control Pills	☐ Diuretics	☐ Pain Killers	☐ Yeast/Fungal Med's

_____

_____

_____

Surgeries/Hospitalizations What surgeries, operations, traumas, fractures, injuries etc. have you had? Please include the *date*.

☐ Appendectomy	☐ Breast Implants	☐ C-Sections	☐ Eye Surgery	☐ Laparoscopy	☐ Broken Bones
☐ Arthroscopy	☐ Biopsies	☐ D&Cs	☐ Implants/Prostheses	☐ Tonsils/Adenoids	☐ Other (Please list below)

Please list all with brief details such as date, outcome, etc. _____

_____

_____

_____

_____

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Family History Check those that apply and indicate the age of onset and outcome of the condition.

	Maternal		*Paternal*							
	Grandpa	*Grandma*	*Grandpa*	*Grandma*	*Mother*	*Father*	*Brother(s)*	*Sister(s)*	*Age of Onset*	*Outcome*
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Arthritis (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Cancer (type)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.
Thyroid Imbalance	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____.

Other _____.

Review of Systems Please check the "Now" box for all conditions that you are currently experiencing and mark the "Past" box for any condition or symptoms experienced at any time in your life. Use the space below for additional details if necessary.

General	Now	Past
Weight Loss	☐	☐
Weight Gain	☐	☐
Head		
Headache	☐	☐
Dizziness	☐	☐
Head Trauma	☐	☐
Fainting	☐	☐
Blacking Out	☐	☐
Eyes		
Change in Vision	☐	☐
Cataracts	☐	☐
Light Sensitivity	☐	☐
Flashes in Vision	☐	☐
Spots in Vision	☐	☐
Mouth		
Bleeding Gums	☐	☐
Cold Sores	☐	☐
Dentures	☐	☐
Sore Throat	☐	☐
Jaw Pain	☐	☐
Changes in Taste	☐	☐
Hoarseness	☐	☐

Nose	Now	Past
Nosebleeds	☐	☐
Sinus Problems	☐	☐
Lungs		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing phlegm	☐	☐
Coughing blood	☐	☐
Tuberculosis	☐	☐
Vascular		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle Swelling	☐	☐
Cold feet/hands	☐	☐
Leg Cramps	☐	☐
Calf Pain	☐	☐
Varicose Veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐

G-I System	Now	Past
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gall bladder disease	☐	☐
Liver Disease	☐	☐
G-U System		
Difficulty urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐

Neurologic	Now	Past
Seizures/Epilepsy	☐	☐
Strokes	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
Muscle/Bone		
Joint pain	☐	☐
Stiffness	☐	☐
Muscle Ache	☐	☐
Arthritis	☐	☐
Bone pain	☐	☐
Fractures	☐	☐
Dislocations	☐	☐
Skin		
Rash	☐	☐
Bruising	☐	☐
Brittle nails	☐	☐
Changes in moles	☐	☐
Itching	☐	☐
Peeling	☐	☐

Conditions	Now	Past
Hypertension	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatic arthritis	☐	☐
Rheumatic fever	☐	☐
Glaucoma	☐	☐
Alcoholism	☐	☐
Cancer/Tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
Osteoarthritis	☐	☐
High cholesterol	☐	☐
Migraines	☐	☐
TIAs	☐	☐
Headache *unlike any previously experienced*	☐	☐

For Women Only	Now	Past
Birth Control _____	☐	☐
Hormone Replacement	☐	☐
Cramps/Backaches	☐	☐
Excessive Flow	☐	☐

	Now	Past
Irregular Cycle	☐	☐
Miscarriage	☐	☐
Painful Periods	☐	☐
Vaginal Discharge	☐	☐

	Now	Past
Hot Flashes	☐	☐
Breast Pain/Tenderness	☐	☐
Pregnant	☐	☐

Date of Last GYNECOLOGICAL Exam : _____

Additional Comments (Please include any additional comments or use this space for overflow from previous pages)

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MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____ _____

Signature of patient or person acting on patient's behalf Date

……

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ _____

Signature of patient or person acting on patient's behalf Date

……

OFFICE POLICIES

I certify that I have read and agree to the **Office Policies**.

x _____ _____

Signature of patient or person acting on patient's behalf Date