Confidential Patient Health Record Date: _____

Personal History

_____ _____

Last Name First Name MI Address

_____

City State Zip Code

Birth Date: _____ Age: _____ Sex: M ____ F____ E-Mail Address _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Circle One: Married Single Widowed Divorced Separated Driver's License #: _____

Employer: _____ Type of Work: _____

Spouse's Name: _____ Spouse's Employer: _____

Referred to this office by _____

Name & Number of Emergency Contact: _____ Relationship _____

Who is responsible for your bill, you and?: Circle One Below

Spouse Worker's Comp. Auto Insurance Medicare Medicaid Health Insurance

Insured Person's Name: _____ Date of Birth: _____

Current Health Condition

Condition bringing you to us? _____

Other doctors seen for this condition? No Who? _____

When did this condition begin? _____ Has this condition occurred before? No

How did symptoms begin? Gradual Sudden Progressive Over Time

What makes symptoms worse? _____ Better? _____

Type of Pain: Sharp Dull Ache Burn Throb Does Pain radiate? Arm Leg Does not radiate

Do you experience numbness or tingling? No

How often do you experience these symptoms? 100%

Pain Intensity: Please circle the number on the scale which best describes the intensity of your pain.

No Pain 1 Worse Pain

Is this condition: Job related Auto Accident Home Injury Fall Other _____

Date of Accident: _____ Have you reported accident to appropriate people? No

Prescriptions You Take: _____

Do you suffer from any condition other than that which you are now consulting us? _____

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Past Health History

Please circle all major surgeries that apply: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery

Prostate Rotator Cuff Hysterectomy Broken Bones Other: _____

Major Accidents or Illnesses: _____

Hospitalization (other than above) _____

Previous Chiropractic Care: No Doctor's Name: _____ Last Visit: _____