Chiropractic Care Center, NW, P.S., Inc.

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Confidential Patient Health Record

Please Complete Both Sides of Form DATE: _____

PERSONAL HISTORY

Name _____
Address _____
City _____ State _____ Zip_____
Date of Birth _____ Age ___ Male or Female
Home Number _____
Cell Number _____
Preferred Phone (circle one) Home Cell Work
Email Address _____
Circle One: Married Single Widowed Divorced
Name & ages of children _____
Referred to this office by _____

Business Employer _____
Business Phone_____
Type of Work _____
Name of Spouse _____
Spouse's Employer _____
Spouse's Business Phone _____
Spouse's Type of Work _____
Emergency Contact _____
Contact's Phone Number _____
Relationship to Contact _____
SSN (optional) _____

Who is Responsible for your bill? You and Spouse Worker's Comp Auto Insurance Medicare

Insurance Company _____
Insurance ID# _____

Policy Holder _____
Policy Holder's Date of Birth _____

CURRENT HEALTH CONDITIONS

Condition for which you are seeking treatment _____
Have you seen any other doctors for this condition? Yes No If yes, who? _____
Type of Treatment _____
When did this condition begin? _____
Results _____
Has this condition occurred before? Yes No
Is this condition: Job Related Auto Accident Home Injury Other _____
Date of Accident _____
Time of Accident_____
If job related, have you made a report of injury to employer? Yes No
Drugs you take now: _____
Do you wear a shoe lift? Yes No
Do you suffer from any other conditions other than what you are now consulting us? _____

PAST HEALTH HISTORY

Please Circle and Describe:
Major Surgeries/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones
Other: _____
Major Accidents or Falls _____
Hospitalizations (other than those above)_____
Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit_____

Name _____ Date _____ D.O.B. _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully, as these problems can affect your overall course of care:

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

__ Tuberculosis
__ Heart Disease
__ Diabetes
__ Cancer
__ Anemia
__ Hepatitis
__ Rheumatoid Arthritis
__ Eczema
__Degenerative Arthritis
__ Lupus
__ HIV
__ Pneumonia
__ Rheumatic Fever
__ Thyroid
__ Epilepsy
__ Pleurisy
__Polio
__ Mental Disorders
__ Measles
__ Small Pox
__ Mumps
__ Chicken Pox
__ Influenza

INTAKE:

__ Cigarettes
__ Drugs
__ Alcohol
__ Coffee
__ Tea

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

__ Low back pain
__ Pain between shoulder
__ Neck Pain
__ Arm Pain
__ Joint Pain/Stiffness
__ Walking Problems
__ Difficulty Chewing
__ Clicking Jaw
__ General Stiffness

NERVOUS SYSTEM

__ Nervousness
__ Numbness
__ Paralysis
__ Dizziness
__ Forgetfulness
__ Confusion/Depression
__ Fainting
__ Convulsions
__ Cold/Tingling Extremities
__ Stress

GENERAL

__ Fatigue
__ Allergies
__ Loss of Sleep
__ Fever
__ Headaches

GENITO-URINARY

__ Bladder Trouble
__ Painful/Excessive Urination
__ Discolored Urination

GASTRO-INTESTINAL

__ Poor/Excessive Appetite
__ Excessive Thirst
__ Frequent Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Liver Problems
__ Gall Bladder Problems
__ Weight Trouble
__ Abdominal Cramping
__ Gas/Bloating after meals
__ Heartburn
__ Black/Bloody Stools
__ Colitis

EARS/EYES/NOSE/THROAT

__ Vision Problems
__ Dental Problems
__ Sore Throat
__ Ear Aches
__ Hearing Difficulty
__ Nasal Congestion

MALE/FEMALE

__ Menstrual Irregularity
__ Menstrual Cramps
__ Vaginal Pain/Infection
__ Breast Pain/Lumps
__ Prostate/Sexual Dysfunction
__ Other _____

_____

C-V-R

__ Stroke
__ Chest Pain
__ Shortness of Breath
__ Blood Pressure Problems
__ Irregular Heartbeat
__ Heart Problems
__ Lung Problems/Congestion
__ Varicose Veins
__ Ankle Swelling

FEMALES ONLY:

When was your last period?

_____

Are you pregnant? Yes No

FAMILY HISTORY

The following members have the same or similar problems I do:

__ Mother
__ Father
__ Brother
__ Sister
__ Spouse
__ Child