

Confidential Patient Health Record

Today's Date: ___ / ___ / ___

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. other: _____

Last: _____ First: _____ Middle: _____

Birth Date: ___ / ___ / ___ Age: _____ Sex: Male / Female Social Security #: _____ - _____ - _____

Marital Status: Single Married Widowed Divorced Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Home Phone: (____) _____ - _____ ext _____ Work Phone: (____) _____ - _____ ext _____

Cell Phone: (____) _____ - _____ ext _____ Fax #: (____) _____ - _____ ext _____

Email Address: _____ Spouses Name: _____

Emergency Contact

Last: _____ First: _____ Middle: _____

Relationship: Spouse Relative Friend Other _____

Home Phone: (____) _____ - _____ ext _____ Cell Phone: (____) _____ - _____

Employment Information

Business Name: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Phone: (____) _____ - _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now

KEY:
P=Pins & Needles
S=Stabbing A=Ache
B=Burning N = Numbness

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this Condition BEGIN? ___ / ___ / ___

Has it ever occurred before? Yes No. When? _____

Is the Condition: Auto Related Job Related Home Injury

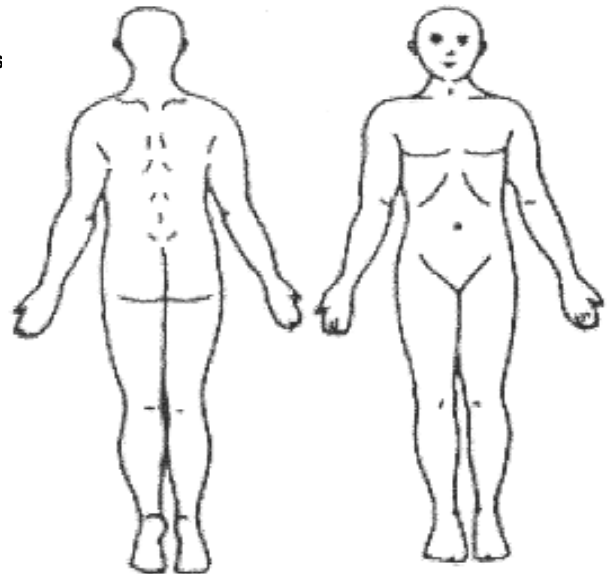
Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New → Acute or Chronic
 Recurrence (Acute) Exacerbation (Acute) Chronic

Current Symptoms: Pain Numbness Stiffness Weakness

Location: Left / Right / Bilateral _____

Quality: Burning Diffuse Dull/Aching Localized Radiating Sharp Shooting
 Stabbing Throbbing Tightness Tingling Other _____

Level of Impairment Due to Symptoms (Resting):

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Level of Impairment Due to Symptoms (With Activity):

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Most Pain)

Duration: Started: _____ Last Occurred: _____

Last episode: _____ Resolved Previous Visit: _____

Worsened: _____ Injury Occurred: _____

Accident Occurred: _____

Timing: *Worse:* Morning Afternoon Night with Activity; Constant Intermittent

Context: *Better with:* Warm Temp Cold Temp *Worse with:* Warm Temp Cold Temp Damp

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Irritability/Mood Swing Localized Tingling Nausea
 Ringing in Ears Sleep Disturbance Stiffness

Headaches: Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus

Quality: Dull Sharp Throbbing Stabbing Aura No Aura

Types: Hat Band Cluster Migraine Tension

Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

- | | | | | |
|---------------------------------------|--|--|--|---|
| <input type="checkbox"/> aches | <input type="checkbox"/> burning | <input type="checkbox"/> cold limb(s) | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> ecchymosis | <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> heartburn | <input type="checkbox"/> joint stiffness |
| <input type="checkbox"/> muscle spasm | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> nausea | <input type="checkbox"/> numbness | <input type="checkbox"/> pale bluish skin |
| <input type="checkbox"/> panic | <input type="checkbox"/> pins & needles | <input type="checkbox"/> rhinorrhea (runny nose) | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sweating |
| <input type="checkbox"/> swelling | <input type="checkbox"/> tingling | <input type="checkbox"/> vomiting | | |

Modifying Factors:

Symptoms Better With: nothing helps activity bending applying cold applying heat
 massage movement OTC meds Rx meds rest
 stretching sitting standing twisting walking

Since condition began, has anything permanently helped you? YES NO

Has anything that you have done, thus far, fixed you problem? YES NO

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)

Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Lifting Postures: with Arms High Near from Knee Off Posture from Torso

Work Activity Postures: (hrs/day)

bending: _____ h/d climbing: _____ h/d kneeling: _____ h/d pulling: _____ h/d pushing: _____ h/d

- difficulty swallowing
- discharge
- dizziness
- fainting
- frequent sore throats
- headaches
- hoarseness
- loss of sense of smell
- nasal congestion
- rhinorrhea (runny nose)
- sinus infections
- snoring
- TMJ problems

Respiration: I DENY having any of the symptoms or problems listed below.

- asthma
- coughing up blood
- cough
- sputum production
- wheezing

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort)
- chest pain
- claudication (leg pain/ache)
- heart murmur
- heart problems
- high blood pressure
- low blood pressure
- orthopnea (difficulty breathing lying down)
- palpitations
- paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)
- shortness of breath with exertion or exercise
- swelling of legs
- ulcers
- varicose veins

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- abdominal pain
- belching
- black - tarry stools
- constipation
- diarrhea
- difficulty swallowing
- heartburn
- hemorrhoids
- indigestion
- jaundice
- nausea
- rectal bleeding
- abnormal stool caliber
- abnormal stool color
- abnormal stool consistency
- vomiting blood
- vomiting

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control
- breast lumps/pain
- burning urination
- cramps
- frequent urination
- hormone therapy
- irregular menstruation
- pregnancy
- urine retention
- vaginal bleeding
- vaginal discharge

Male: I DENY having any of the symptoms or problems listed below.

- burning urination
- erectile dysfunction
- frequent urination
- hesitancy/ dribbling
- prostate problems
- urine retention

Endocrine: I DENY having any of the symptoms or problems listed below.

- cold intolerance
- diabetes
- excessive appetite
- excessive hunger
- excessive thirst
- abnormal frequency of urination
- goiter
- hair loss
- heat intolerance
- unusual hair growth
- voice changes

Skin: I DENY having any of the symptoms or problems listed below.

- changes in nail texture
- changes in skin color
- hair growth
- hair loss
- hives
- history of skin disorders
- itching
- paresthesias
- rash
- skin lesions / ulcers
- varicosities

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness
- facial weakness
- headache
- limb weakness
- loss of consciousness
- loss of memory
- numbness
- seizures
- sleep disturbance
- slurred speech
- stress
- strokes
- tremor
- unsteadiness of gait

Psychologic: I DENY having any of the symptoms or problems listed below.

- anhedonia
- anxiety
- loss or change in appetite
- behavioral change
- bi-polar disorder
- confusion
- convulsions
- depression
- insomnia
- memory loss
- mood change

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis
- food intolerance
- itching
- acute nasal congestion
- chronic nasal congestion
- rash
- sneezing

Hematologic: I DENY having any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
 bleeding blood transfusion fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD chicken pox headaches scoliosis
 atopic dermatitis (eczema) crohn's/colitis hepatitis seizure disorder
 allergies/hayfever depression HIV sickle cell anemia
 anemia diabetes measles spina bifida
 asthma ear infections mumps other:
 bedwetting fetal drug exposure psoriasis
 cerebral palsy food allergies (list below) rash

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD cystic kidney disease hypertension psychiatric problems
 alzheimers depression influenzal pneumonia scoliosis
 anemia diabetes (insulin dep) liver disease seizures
 arthritis diabetes (non insulin) lung disease shingles
 asthma eczema lupus erythema (discoid) past history of similar symptoms
 cancer emphysema lupus erythema (systemic) STD's (unspecified)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental sugery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

- | | | | | | |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Social History: Mark all that apply below.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
 beer liquor wine; quantity of _____ oz./glasses per day week month

My Dietary Intake consists mainly of the following: (mark all that apply)

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> high fat | <input type="checkbox"/> high salt | <input type="checkbox"/> low fiber |
| <input type="checkbox"/> high fiber | <input type="checkbox"/> low calorie | <input type="checkbox"/> low salt |
| <input type="checkbox"/> high protein | <input type="checkbox"/> low carbohydrate | <input type="checkbox"/> low sugar |

Tobacco: Do not use tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
 Smoke: # ____ per Day Week Month; Chew: # ____ cans per Day Week Year

Disclaimer:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Marshalls Creek Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Marshalls Creek Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor(s) *Brett and Anne Marie Coryell* to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Copies of X-Rays and medical records are available to me at a fee that can be further discussed with our office employee who handles medical records. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____

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