COMMUNITY CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH RECORD

Name_____ Date:_____Date of Injury_____

Address_____City/State_____Zip_____

Date Of Birth_____ Age_____ Home Phone_____ Cell Phone_____

Marital Status_____Number of Children_____ Name of Spouse_____

Spouse's Phone Number_____Spouse's Employer_____

Occupation_____Name of Employer_____

Employer's Address_____

Other Nearest Relative_____ Phone Number_____

Social Security Number_____Health Insurance_____Auto Ins_____

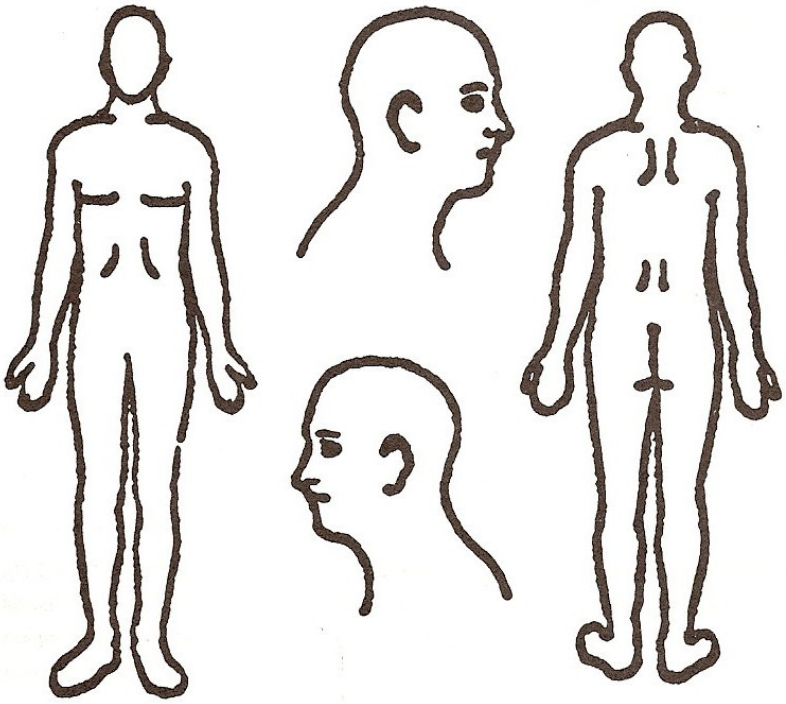
Who referred you to this office?_____

If the patient is a minor, I hereby give consent and permission to treat (Child's Name)_____

Signature of Parent or Guardian_X_____Relationship to patient_____

Dear Patient: This information is confidential. We need this information because we care enough to want to know. Your answers will help us determine if and what kind of chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and thorough as possible. Thank you.

Please mark your areas of pain on the figures below



Please Describe the principal health problems for which you came to this office:

_____

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How long have you had these conditions?_____

How did this (these) condition(s) develop?_____

Please list any other doctors you have seen for these problems_____

List the diagnoses and the treatments type(s)_____

Have you lost any days from work? Yes_____ No_____ Dates_____
Have these problems been getting better_____ worse_____ staying the same_____
What functions are you unable to perform or induce pain upon performance? (example: sitting, walking, standing, lifting, turning head)

_____

Is there anything that you do that makes you feel better?_____
How long has it been since you had:

Complete Physical Exam_____

Spinal Exam_____

Dental Check-up_____

X-rays taken_____ of what part of your body_____

Eye Examination_____

Gynecological Exam (if applicable)_____

FOR WOMEN ONLY:
Are you pregnant? Yes_____ No_____ If yes, how many months along?_____

How many times have you been pregnant?_____

How many times did you deliver?_____

Were there any health problems during the pregnancy or any complications during the delivery? Yes_____ No_____ If yes, please explain:

_____
Have you ever taken oral contraceptives? Yes____ No____ Are you taking them now? Yes____ No____
Have you ever used an IUD? Yes____ No____ Are you using one now? Yes____ No____
Please circle any of the following symptoms that you experience before, during or after menstruation: (please circle all that apply)

cramps back pain swelling emotional changes bloating bowel issues fatigue head-ache
How many days in your cycle typically:_____

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT!

Name of person responsible for payment:_____
Do you have insurance? Yes____ No_____ If yes, insurance company_____
I understand that health and accident insurance policies are an arrangement between the carrier and myself. Furthermore, I understand that this chiropractic office will prepare and necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account . However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care or treatment in this office, any fees for services rendered will be immediately due and payable.
Patient Signature_____Date_____

Guardian or spouse's signature authorizing care_____ Date_____