Confidential Patient Health Record

Date:	

Integrative Chiropractic Center
Initial Visit Information

Name:____________________________________

Address:__________________________________

City/ State/ Zip:___________________________

Home Phone:_______________________________

Business Phone:_____________________________

Mobile Phone:______________________________

E-mail:___________________________________

Date of Birth: ____________ Age: ____ Sex: M/ F

Business Employer:__________________________

Type of work:______________________________

Name of spouse:____________________________

Names and ages of your children: ____________

____

Who referred you to our office?

____

Insurance company: _______________________

Primary on Insurance: _____________________

Date of Birth of Primary: __________________

Emergency contact and number: _____________

____

Current Health History

Purpose of this appointment: ____

When did this condition begin? ____________________ Has this condition occurred before? Yes No

How did this condition occur? ____

Have you seen any other doctors for this condition? No Yes Who? __________________________

Type of treatment: ______________________________ Medications? ______________________

Type of pain: Sharp/Shooting Dull/Achy Tingling Burning Other

Activities that are painful: Sitting Standing Walking Bending Lying down

Rate the pain on a scale from 1 (least pain) to 10 (most pain): ___________________________

Is the pain constant or does it come and go? ____

Does it interfere with your: Work Sleep Daily Routine Recreation

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

If job related, have you filed a report of the accident to your employer? Yes No

Vitamins/Supplements: ____

Past Health History

Major Surgery/Operations? ____

Major Accidents or Falls? ____

Have you ever been in a motor vehicle accident? If so, when?______________________________

Hospitalizations? (other than above)____

Previous Chiropractic Care? No, never If yes, please give the doctor's name/location and approximate date of last visit ____

Who is your Medical Doctor (s)? ____

HABITS: Smoking_________packs/day Alcohol ____________ drinks/week Caffeine ________cups/day

Exercise: (circle one) none moderate daily heavy

Below is a list of diseases that 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 chiropractic care.

Circle If You Have Ever Had:

Pinched Nerve
Osteoporosis
Thyroid Problems
Pacemaker
Hernia
Herniated Disk
Pneumonia
Rheumatic Fever
Polio
Tuberculosis
Whooping Cough

Anemia
Measles
Diabetes
Fractures
Bronchitis
Migraines
Anemia
Pleurisy
Arthritis
Epilepsy
Mental Disorders

Eczema
Heart Disease
High Blood Pressure
High Cholesterol
Cancer
____

MRI/X-RAY
Results:
____

Daily Intake:
Coffee ____/day
Tea _____/day
Soda ______/day
Alcohol ______/day
Cigarettes _____/day

Circle If You Have Had Any Of The Following In The Last Six Months:

General
Headaches
Fatigue
Allergies
Loss of Sleep
Fever

Musculo-Skeletal
Low Back Pain (Left or Right)
Sciatica (Left or Right)
Pain Between Shoulders
Neck Pain (Left or Right)
Shoulder Pain (Left or Right)
Arm Pain (Left or Right)
Hand Pain (Left or Right)
Knee Pain (Left or Right)
Foot Pain (Left or Right)
Joint Pain/ Stiffness
Walking Problems
Jaw Pain/ Clicking
General Stiffness

Nervous System
Nervous
Numbness Where? _________
Paralysis
Dizziness
Forgetfulness
Confusion
Depression
Fainting
Convulsions
Cold/ Tingling Extremities
Stress

Gastro-Intestinal
Poor/ Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Problems
Gall Bladder Problems
Weight Trouble
Abdominal Cramps
Gas/ Bloating after meals
Heartburn
Black/Bloody Stool
Colitis

Genito-Urinary
Bladder Trouble
Pain/Excessive Urination
Discolored Urine

Cardiovascular/ Pulmonary
Chest Pain
Short Breath
Blood Pressure Problems
Irregular Heartbeat
Heart Problems
Lung Problems
Congestion
Varicose Veins
Ankle Swelling
Stroke

EENT
Vision Problems
Dental Problems
Sore Throat
Earaches
Hearing Difficulty
Stuffed Nose

Males Only:
Prostate Problems
Other Problems
____

Females Only:
When was your last period?
____
Are you pregnant? Yes No
Could you be? Yes No
Menstrual Irregularity
Menstrual Cramps
Vaginal Pain/ Infection
Breast Pain/ Lumps
Oral Contraceptives
Other:_____________________

Additional Problems:
____
____

Family History
The following have similar problems as I have:
Mother Father
Brother Sister
Children