# CONFIDENTIAL PATIENT HEALTH RECORD

**Date:_____**

## PERSONAL HISTORY

Name:_____ Birth Date:_____
Address:_____ City:_____ Postal Code:_____
Home Phone:_____ Work Phone:_____
Business/Employer:_____ Type of work:_____
Email:_____ Gender M___F___ Number of Children: _____
Emergency Contact:_____ Phone :_____ Relationship:_____

Whom shall we thank for referring you to our office? _____

## CURRENT HEALTH CONCERN

Reason for consulting our office today? _____
_____

What other methods have you used for relief or correction of this health concern? _____
_____

When did symptoms start? _____ Has this occurred before? _____
Is this condition job related? ____auto accident?____ fall?____ sports injury? ____ other_____
Current or recent drugs taken: muscle relaxants ____ pain killers ____ steroids ____insulin____
Blood pressure ____birth control ____supplements____
Do you suffer from any other health conditions? _____

## QUALITY OF LIFE

*Please check **ALL** of the following that complete the next sentence for you:*

**"This condition has robbed me of my ability to enjoy/perform…."**

□ active living
□ playing with my kids
□ playing with my pets
□ walking/hiking
□ standing comfortably
□ sitting comfortable
□ remembering things
□ sleeping well
□ sexual function
□ relationships
□ climbing stairs
□ home maintenance
□ gardening
□ driving
□ my work duties
□ breathing
□ care giving duties
□ concentrating
□ playing sports like: _____
□ my favorite hobbies: _____
□ other: _____

It is most important to me that I regain my ability to: _____

**Please check ALL of the following symptoms that you have experienced in the past 6 months:**

□ stress
□ loss of sleep
□ dizziness
□ fatigue
□ confusion
□ forgetfulness
□ headaches
□ clicking jaw
□ arm pain
□ leg pain
□ ankle swelling
□ chest pain
□ breast pains
□ blood pressure problems
□ allergies
□ frequent nausea
□ vomiting
□ excessive thirst
□ heartburn
□ diarrhea
□ constipation
□ abdominal cramps
□ hemorrhoids
□ liver problems
□ gall bladder problems
□ bladder trouble
□ painful urination
□ discolored urine
□ sexual dysfunction
□ menstrual cramps
□ neck pain
□ paralysis
□ numbness
□ tingling extremities
□ pain between shoulders
□ general stiffness
□ chronic infections
□ low back pain
□ walking problems
□ decreased immunity
□ shortness of breath
□ asthma
□ lung problems
□ heart problems

**FEMALES ONLY**:
Are you pregnant? Yes ___ No ___ Date of last menstrual period? _____

# PAST HEALTH HISTORY

Have you had previous chiropractic care? Yes ___ No ___ Doctor's Name: _____
Date of last adjustment: _____
Have you had recent chiropractic x-rays taken? Yes ___ No ___ When ? _____
List any previous surgeries _____
List any automobile accidents, falls, sports or other injuries: _____
_____
List any hospital stays: _____
Family members with same or similar condition: Yes ___ No___ Relation: _____
Do you or your immediate family have a history of: □ heart disease □ diabetes □ cancer
□ stroke □ other:

Patient Signature: _____ Date: _____