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
What makes it better: _____
What makes it worse: _____
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:_____
Do you meditate: Yes No
Do you take time out of the day for yourself? _____
How stressed do you think you are? (circle one) : least < 1 2 3 4 5 >most
What do you consider your biggest stressor? _____
Do you sleep well and wake up refreshed? Yes No
How many hours of sleep do you get a night? _____

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)? _____

Medications? _____

Supplements? _____

Weight: _____ **Height:_____**

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