Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State/Prov _____ Zip/Postal Code _____
Home Phone _____ **Birth date** _____
Mobile Phone _____
Social Security # _____ Driver's License / ID Number _____
Email Address _____ Circle One: Married Single Widowed Divorced Separated
Business Employer _____ Type of Work _____
Business Phone _____ Spouse's Social Security# _____
Name of Spouse _____ Spouse's Insurance # _____
Spouse's Employer _____ Spouse's Contact # _____
Type of Work _____ Spouse's Birth Date _____
Referred To This Office By _____
Name and Number of Emergency Contact: _____ # _____ Relationship: _____
Who Is Responsible for Your Bill You and ☐ Spouse ☐ Worker's Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid
☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

CURRENT HEALTH CONDITION

Purpose of This Appointment _____
Have You Seen Other Doctors For This Condition: ☐ No ☐ Yes Who? _____
Type of Treatment: _____
Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

PERSONAL HISTORY

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other _____

CURRENT MEDICAL HISTORY

What is your primary area of concern today? _____
Has this symptom occurred before? ☐ Yes ☐ No **When did it start?** _____
What caused it to start? _____
How often is it a problem for you? ☐ CONSTANTLY (*100% of the time*) ☐ FREQUENTLY (*less then 75% but more than 50%*)
☐ OCCASIONALLY (*less than 50% but more than 25%*) ☐ INTERMITTENTLY (*less than 25% of the time*)
How intense is your discomfort on a scale of 0 to 10, with 10 being the worst possible pain and 0 being no pain? _____
How do you relieve this discomfort? _____ **What activity or position aggravates the discomfort?** _____
What term(s) best describe your discomfort? (*Check all that apply*)

☐ ACHING	☐ DEEP	☐ HEAVY	☐ SHARP	☐ STIFFNESS	☐ TINGLING
☐ ANNOYING	☐ DIFFUSE	☐ INTOLERABLE	☐ "SHOCK-LIKE"	☐ THROBBING	
☐ BURNING	☐ DULL	☐ PULLING	☐ STABBING	☐ TIGHTNESS	

Do you have any additional areas of concern? (*refer to terms and scale above*)

_____
_____
_____
_____

Below are a list of diseases which 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.

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Eczema
- ☐ Back Pain

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? Yes No Do you take vitamins? ☐ No ☐ Yes ☐ Regularly ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Disease/Dialysis

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE

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

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:
Are you pregnant?

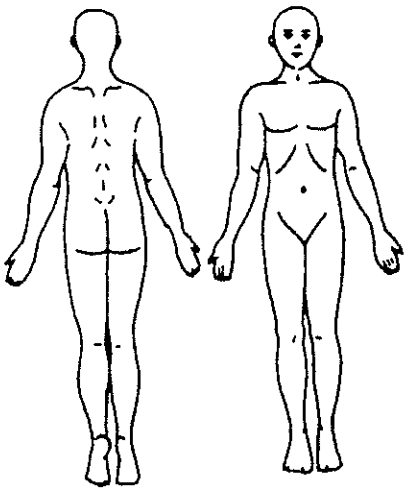
☐ Yes ☐ No ☐ Not sure

Nursing? ☐ NO ☐ YES

When was your last period? _____

FAMILY HISTORY
Please indicate any health problems The following have:

Mother: _____
Father: _____
Brother: _____
Sister: _____
Spouse: _____
Child: _____



Please circle on the diagram the area(s) of your discomfort

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS
DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Broken Bones

☐ Other: _____

Major Accident or Falls: _____

_____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

WORK INFO:

The type of work performed: ☐ Office/Clerical ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

Have you been able to work since this injury? ☐ yes ☐ no

How many hours/days are in your normal work week? _____ hrs. _____ Days

While in recovery, is there any light duty work you can request? ☐ yes ☐ no

Please check your daily duties and any activities that you are occasionally asked to perform. ☐ Lifting ☐ Standing

☐ driving ☐ operating equip. ☐ sitting ☐ twisting ☐ jumping ☐ climbing ☐ walking ☐ typing

☐ work w/arms overhead ☐ crawling ☐ pulling ☐ bending ☐ stooping ☐ other: _____

I hereby authorize Dr. Gittens to examine me, including take X-ray(s) if indicated by the exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and request that all my records be held in strict confidence and not be given to anyone without my written consent. I clearly understand that I am totally responsible for all charges should my insurance company deny payment.

By signing my name below, I certify the accuracy of my medical and/or accident history and further certify that I present myself to Dr. Gittens for evaluation and/or treatment of a health related condition.

Patient's Signature: _____ *Date* _____

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and therefore consent to spinographic pictures.

Signed: _____ *Date* _____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic care as deemed necessary to my child.

Signed _____ (Parent/Legal guardian) *Date* _____

I UNDERSTAND and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid direct to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me or my minor child will be immediately due and payable.

Patient's Signature: _____ *Date* _____

Parent or Guardian's Signature: _____ *Date* _____

Information taken by: _____ *Date* _____