Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ State ____________ Zip Code: ____________

Home Phone: ______________________ Birth Date: ____________ Age: ________ Sex: ☐ M ☐ F

Cell Phone: ______________________ E-mail Address: ______________________

Social Security # ______________________ Driver's License Number: ______________________

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________

Name of Spouse ______________________ Spouse's Social Security # ______________________

Spouse's Employer ______________________ Business Phone ______________________

Type of Work ______________________ Name and Ages of Children ______________________

Referred To This Office By: ______________________ ______________________

Name and Number of Emergency Contact: ______________________ Relationship: ____________

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) ______________________ ☐ Health Card # ______________________

Insured Person's Name ______________________ Date of Birth ______________________

CURRENT HEALTH CONDITION

Unwanted Health Condition ______________________

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? ______________________

Type of Treatment: ______________________ Results: ______________________

When Did This Condition Begin? ______________________ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: ______________________

Date of Accident: ______________________ Time of Accident: ______________________

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other ______________________

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? ______________________

____

PAST HEALTH HISTORY

Please Check and Describe:

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

☐ Broken Bones ☐ Other ______________________

Major Accident or Falls: ______________________

____

Hospitalization (Other Than Above): ______________________

____

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