



Patient # _____

CONFIDENTIAL PATIENT HEALTH RECORD

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Internet Insurance Plan Drove by _____

Personal Information:

Last: _____ First: _____ Middle: _____
 Suffix: Jr. Sr. II III DC MD PhD DO Esq PA RN Other _____
 Birth Date: _____ Age: _____ Sex: Male / Female Social Security # _____
 Marital Status: Single Married Widowed Divorced Separated Partnered
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Email Address: _____ Spouse's Name: _____
 Children (Name and ages): _____

Emergency Contact:

Last: _____ First: _____ Middle: _____
 Suffix: Jr. Sr. II III DC MD PhD DO Esq PA RN Other _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Relationship: Spouse Relative Friend Other _____

Employment Information:

Business Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Occupation/Job Title: _____ Job Description: _____

Insurance Information

Insurance Company _____ ID# _____ Group# _____
 Subscriber Name _____ DOB: _____ Relation to patient _____

Name: _____

Patient # _____

Current Health Condition:

Present Complaint(s): Why are you here today? _____

When did this Condition/Pain **BEGIN**? _____

Has it ever occurred before? Yes No When? _____

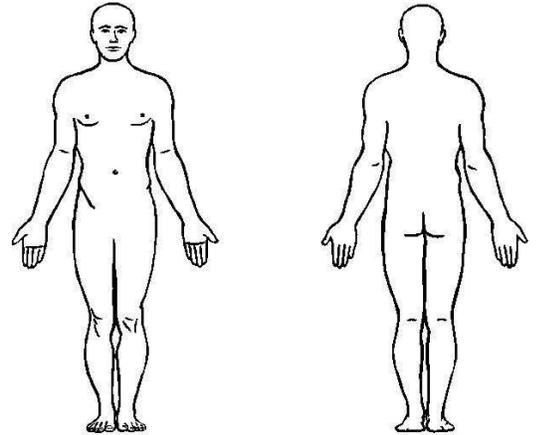
- Is the Condition: Auto Related Date: _____
 Work Related Date: _____
 Slip or Fall
 Lifting
 Slept Wrong
 Unknown Cause
 Other _____

Do you **SUFFER** from **ANY OTHER** Condition than which you are now consulting us? _____

Don't just rate the hurt; rate how it's affecting your life.

Use the letters **BELOW** to indicate the **TYPE** and **LOCATION** of your sensations right now.

**Key: A=Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing**



0 Pain Free	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating/ Unbearable	10 Unimaginable/ Unspeakable
NO PAIN	MINOR PAIN			MODERATE PAIN			SEVERE PAIN			
You are living life as per usual.	Pain does not limit your activity; you are still living a normal life with a little bit of pain added in.			Your pain is <i>somewhat</i> disabling - you might avoid activities that exacerbate it.			Your pain is <i>extremely</i> disabling. It has drastically affected your quality of life and is always on your mind.			

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition

If YES by whom? _____ When? _____

Treatment _____ Satisfied with results? YES NO

Explain: _____

Previous Chiropractic Care:

I have not previously had chiropractic care.

If YES by whom? _____ When? _____

Satisfied with your care? YES NO

Explain: _____

Do you wear any of the following? Heel lifts Innersoles Arch supports Orthotics Other _____
For how long? _____ Were they prescribed by a doctor? YES NO

Name: _____

Patient # _____

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Childhood Illness(es): Place a mark to indicate if you have had any of the following.

- ADD
- depression
- hepatitis
- seizure disorders
- allergies/hay fever
- diabetes
- measles
- sickle cell anemia
- anemia
- ear infections
- mumps
- Spina Bifida
- bedwetting
- eczema
- psoriasis
- chicken pox
- fetal drug exposure
- rash
- Crohn's/colitis
- headaches
- scoliosis

Do you believe that the Adult Illness below are contributory to your CURRENT condition? YES NO

Adult Illness(es): Place a mark to indicate if you have had any of the following.

- ADD
- depression
- HIV
- scoliosis
- anemia
- diabetes (insulin dependent)
- hypertension
- seizures
- arthritis
- diabetes (non-insulin)
- influenza pneumonia
- shingles
- asthma
- eczema
- liver disease
- STD
- cancer
- emphysema
- lung disease
- suicide attempt(s)
- Cerebral palsy
- fibromyalgia
- lupus
- vertigo
- chicken pox
- heart disease
- multiple sclerosis
- Other: _____
- Crohn's/colitis
- hepatitis
- Parkinson's disease
- Pneumonia
- psoriasis
- cystic kidney disease

Current Medication(s): List ANY/ALL medications you are CURRENTLY taking. Be specific.

Medication	Dosage	For what condition?	For how long?

Current vitamins, Herbs, etc.: List ANY/ALL non-prescription items you are CURRENTLY taking. Be specific.

Name	Dosage	For what condition?	For how long?

Surgery(ies): List All procedures. Write the DATE of procedure immediately afterward.

- angioplasty _____
- cosmetic _____
- mastectomy _____
- appendectomy _____
- D&C _____
- pacemaker insertion _____
- caesarian section _____
- dental surgery _____
- rotator cuff _____
- cardiac catheterization _____
- gall bladder _____
- spinal fusion _____
- carpal Tunnel repair _____
- hernia repair _____
- other _____
- coronary artery bypass _____
- hysterectomy _____
- joint reconstruction _____
- joint replacement _____

Injury(ies): Please list ALL injuries. Write the DATE of the injury immediately afterward.

- back injury _____
- head injury _____
- work injury _____
- disability(ies) _____
- joint injury _____
- fracture(s) _____
- motor vehicle injury _____

Non-Drug Allergies: Mark ALL that apply.

- | | | | | |
|--|--|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> dairy | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soap |
| <input type="checkbox"/> animals | <input type="checkbox"/> eggs | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> soy |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> feathers | <input type="checkbox"/> tree nuts | <input type="checkbox"/> shellfish | <input type="checkbox"/> wheat |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> smoke | <input type="checkbox"/> other _____ |

Label the Number(#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

- | | | |
|-------------------|---------------|------------------------|
| 1. anaphylaxis | 3. headache | 5. rash |
| 2. GI disturbance | 4. joint pain | 6. shortness of breath |

Family history: Mark ALL that apply below. List any specific conditions past or present after has/had.

Family Member	Alive (age)	Deceased age	No significant disease	Past condition	Current condition
Father					
Mother					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Son(s)					
Daughter(s)					
Brother(s)					
Sister(s)					

Social History: Mark ALL that apply.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
 beer liquor wine quantity of _____ oz./glasses per day week month

Substance: never used illegal drugs has not used illegal drugs since _____
 Never used IV drugs used illegal drugs for _____ (how long?)

Tobacco: Do not use tobacco do not smoke cigars, cigarettes, or pipe Live with a smoker Quit smoking
Smoke: # _____ per Day Week Month Chew: # _____ cans per Day Week Month

Certification and assignment: To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health. I hereby authorize Dr. Gary Billingsley and Dr. Brookley Pavnica to treat my diagnosed problem(s) as they deem appropriate using chiropractic care. And I give authority for these procedures to be performed.

Print Name

Signature

Date

Guardian Name if Minor

Signature

Date