21st Century Chiropractic

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Confidential Patient Health Records

PERSONAL HISTORY

Today's Date: ______________________

Name: ______________________

Address: ______________________ DOB: ______________________

City: ______________________ SS #: ______________________

State: ______________________ Age: ______________________

Zip: ______________________ Phone: ______________________

Sex: _____ Female _____ Male Cell: ______________________

Email: ______________________ Cell Carrier: ______________________

Would you like to receive our email newsletter? _____ Yes _____ No

Would you like to receive text reminders? _____ Yes _____ No

Spouse Name: ______________________ `

Address: ______________________ Phone: ______________________

City: ______________________ Cell: ______________________

State: ______________________

Zip: ______________________

Name of Emergency Contact (If different than Spouse): ______________________

Emergency Contact Phone#: ______________ Relationship: ______________________

Referred to this Office by: ______________________

EMPLOYMENT INFORMATION

Employer: ______________________ Business Phone: ______________________

Occupation: ______________________ Business Fax: ______________________

FINANCIAL INFORMATION

Who is responsible for your bill?

_____ Self Pay _____Spouse _____Auto Insurance _____ Worker's Comp _____Medicare

____________ This is **NOT** a Work-Related or Worker's Compensation injury

____________ This is **NOT** an Auto Accident related injury

____________ This is **NOT** a Personal Injury case currently under litigation

Patient's Signature:____ Date:_________________

Past Health History

Childhood Illnesses

____None ___Cerebral Palsy ____Asthma ____Chicken Pox
____Headaches ____Seizure Disorder ____Hepatitis ____Diabetes
____Measles ____Mumps ____Spina Bifida
____Unusual Childhood Illnesses_______ ____Serious Illnesses________________

Adult Illnesses

____None ____Arthritis ____Depression ____Hypertension
____Seizures ____Asthma ____Kidney Disease ____Psychiatric Problems
____Stroke(CVA) ____Hepatitis ____Heart Attack ____Thyroid Problems
____Chicken Pox ____Diabetes (insulin) ____Diabetes (noninsulin)
____Cancer_______ ____Serious Illnesses______________

Surgeries

____None ____Angioplasty ____Appendectomy ____Cardiac Catheterization
____Carpal Tunnel ____Coronary Bypass ____D & C ____Hernia Repair
____Pacemaker Insertion ____Tonsillectomy ____Joint Replacement (which joint) _______
____Joint Reconstruction (which joint) _______ ____Laminectomy ____Spinal Fusion
____Hysterectomy total or partial ____Caesarean Section
Spine Surgeries ____
Other Surgeries ____
Broken Bones ____
Head Injuries ____

Smoking Status

Never Smoked___ How long currently Smoked______ Former Smoker__ How long Smoked________
Alcohol: None__________Occasional__________Rarely___________Social_______________
Preferred Language______________________________ **RACE**_________ **Ethnicity**________

Current Health Status

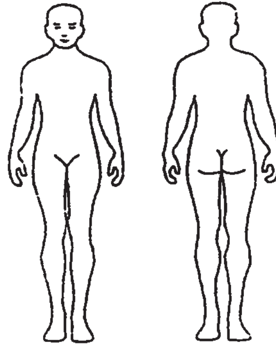
Height_______ Weight________ Blood Pressure ______
Mammogram Never _____ Date of Last Mammogram______
Pnuemonia Vaccine Never ____ Date of Last Vaccine ______
Allergies____
Are You Pregnant? No ____ Due Date __________

Family History

	Alive/Age	Deceased/Age	Any Illnesses
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Sons(s) Number #____			
Daughter(s) # ____			
Brother(s) # ____			
Sister(s) # ____			

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate Health Potential.

Please use the diagram below and mark the area of your first complaint.



What is your primary complaint? ______________________________

Date the symptom first appeared?______________

The condition began:

☐ gradually ☐ suddenly ☐ progressively over time

Explain why or how the condition began. ______________________________

____

How is the condition progressing?

☐ improving ☐ remains the same ☐ progressively worse ☐ recurrent

What does this condition prevent you from doing or enjoying?

What makes the condition worse?

What makes the condition better? ______________________________

What have you tried that has not helped? ______________________________

How does the condition affect your attitude, mood, and stress? ______________________________

Type of pain: ☐ ache ☐ dull ☐ stiffness ☐ sharp ☐ stabbing ☐ shooting ☐ swelling

☐ cramping ☐ burning ☐ throbbing ☐ numbness ☐ tingling ☐ other

Does the pain travel or radiate? ☐ into arm R or L ☐ into leg R or L ☐ other______________ ☐ does not radiate

Rate the severity of your pain or symptoms: from 0 (no pain/no symptoms to 10 (unbearable pain/extreme symptoms)

How frequent is this condition?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

occasional intermittent frequent constant

How long does it last? ☐ All day ☐ most of the day ☐ a few hours ☐ a few minutes

When do you experience the pain? ☐ before activity ☐ with activity ☐ after activity ☐ comes and goes

I have been: ☐ hospitalized ☐ treated by another chiropractor

☐ treated by another provider ☐ never received care for this condition

Are there any other conditions or symptoms that may be related to your major complaint?

☐ No ☐ Yes If yes, please explain

Are there any other unrelated health problems or symptoms?

☐ No ☐ Yes If yes. please explain

REVIEW OF SYSTEMS

- Please read ALL sections and check mark "NONE" if nothing applies.
- Place a check mark in the areas which apply to both Past & Present Conditions

Constitutional:

___ Chills
___ Daytime Somnolence
___ Fatigue
___ Fever
___ Night Sweats
___ Weight Gain
___ Weight Loss
___ **NONE**

Eye / Vision:

___ Blindness
___ Blurred Vision
___ Cataracts
___ Change in Vision
___ Double Vision
___ Eye Pain
___ Field Cuts
___ Glasses/Contacts
___ Glaucoma
___ Itching
___ Photophobia
___ Tearing
___ **NONE**

ENT:

___ Bleeding
___ Dentures
___ Difficulty Swallowing
___ Dischage
___ Dizziness
___ Ear Drainage
___ Ear Pain
___ Fainting
___ Sore Throats
___ Headaches
___ Hearing Loss
___ History head Injuries
___ Hoarseness
___ Loss of Smell
___ Nasal Congestion
___ Nose Bleeds
___ Post Nasal Drip
___ Runny Nose
___ Sinus Infections
___ Snoring
___ Tinnitus (Ringing in Ears)
___ TMJ
___ **NONE**

Respiration:

___ Asthma
___ Cough
___ Coughing up Blood
___ Shortness of Breath
___ Sputum Production
___ Wheezing
___ NONE

Cardio:

___ Angina
___ Chest Pain
___ Claudication
___ Heart Murmur
___ Heart Problems
___ Orthopnea
___ Palpitations
___ PND
___ SOB w/ Exerion
___ Swelling of Legs
___ Ulcers
___ Varicose Veins
___ **NONE**

Gastro:

___ Abdominal Pain
___ Belching
___ Black Tarry Stools
___ Constipation
___ Diarrhea
___ Difficulty Swallowing
___ Heartburn
___ Hemmorrhoids
___ Ingestion
___ Jaundice
___ Nausea
___ Rectal Bleeding
___ Regurgitation
___ Stool Caliber
___ Stool Color
___ Stool Consistency
___ Vomiting
___ Vomiting Blood
___ **NONE**

Female:

___ Breast Lumps/Pain
___ Burning Urination
___ Cramps
___ Frequent Urination
___ Incontinence
___ Irregular Menstruation
___ Urine Retention
___ Vaginal Bleeding
___ Vaginal Discharge
___ **NONE**

Male:

___ Burning Urination
___ Erectile Dysfunction
___ Frequent Urination
___ Dribbling
___ Prostate
___ Urine Retention
___ **NONE**

Endocrine:

___ Cold Intolerance
___ Diabetes
___ Excessive Appetite
___ Excessive Hunger
___ Excessive Thrist
___ Frequent Urination
___ Goiter
___ Hair Loss
___ Heat Intolerance
___ Unusual Hair Growth
___ Voice Changes
___ **NONE**

Skin:

___ Changes in Nail Texture
___ Hair Growth
___ Hair Loss
___ Hx. Of Skin Disorders
___ Hives
___ Itching
___ Paresthesias
___ Pruritis
___ Rash
___ Skin Lesions/Ulcers
___ Varicosities
___ **NONE**

Psychologic:

___ Anhedonia
___ Anxiety
___ Appetite
___ Behavioral Change
___ Bipolar
___ Confusion
___ Depression
___ Insomnia
___ Memory Loss
___ Mood Changes
___ **NONE**

Nervous:

___ Dizziness
___ Facial Weakness
___ Headache
___ Limb Weakness
___ Loss of Consciousness
___ Loss of Memory
___ Numbness
___ Seizures
___ Sleep Disturbance
___ Slurred Speech
___ Stress
___ Strokes
___ Tremor
___ Unsteadiness of Gait
___ **NONE**

Allergy:

___ Anaphalaxis
___ Food Intolerance
___ Itching
___ Nasal Congestion
___ Sneezing
___ **NONE**

Hematology:

___ Anemia
___ Bleeding
___ Blood Clotting
___ Blood Transfusions
___ Bruising
___ Fatigue
___ Lymph Node Swelling
___ **NONE**