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Confidential Patient Health Record

Date: ___________________

Patient Information:

Name: ______________________________ Birth Date: __________________ Phone: ________________________

Gender: **M F** Race: ___________ Ethnicity: **Hispanic/Latino Not Hispanic/Latino**

Preferred Language: ________________ Address: ____

City: _______________________________ State: ______________________ Zip: __________________________

Social Security #: ____________________ Email: ____

Employment Status: **Working Retired Unemployed Part-Time Student Full-Time Student**

Occupation: _______________________ Employer: ____

Marital Status: **Single Married Partnered Widowed Divorced Separated**

Spouse's Name: ____________________ Occupation: ____

Personal Health Insurance Carrier: ____

Insured Person's Name: ____

DOB of Insured: ___________________ Insured's Social Security #:_________________________________

Name of Previous Chiropractor: ____

Name of Medical Doctor: ____

Referred To This Office By: **Print Ad Mailing Search Engine Internet Offer Other:** ________________

Name and Number of Emergency Contact: ____

Patient Condition:

Reason(s) for visit:____

Is this condition due to an accident? **YES / NO Auto Work Home Other** Date:__________________

When did your symptoms appear?___________________________ Is this condition getting worse? **YES / NO**

Is it constant or does it come and go? ______________ Is it worse with rest or activity? _____________________

What do you think caused this problem? ____

Which best describes the character of your pain? **Dull/Ache Sharp Numb Tingling Burning**

Is the pain worse in the AM or PM? ____________________________

What treatments have you already received for your condition?

None Physical Therapy Massage Therapy Medications

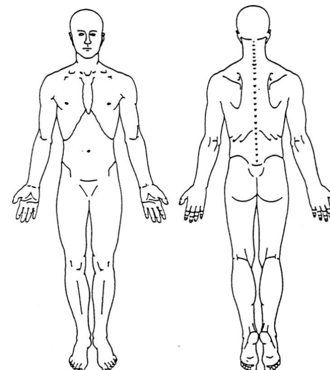
Surgery Chiropractic Other: ________________________

What activities are difficult/painful to perform?

Sit Stand Sit to Stand Walk Bend Drive

Computer Work Lay Down Sleep Other:_________

Mark an "**X**" on the picture where you are experiencing symptoms:



Personal Health History:

Date of Last: Spiral X-Ray _________ MRI _________ CT-Scan _________ Blood Test _________
Colonoscopy _________ Prostate/PSA _________ Pap Smear _________ Mammogram _________

Have you had any surgeries? ____

What medications are you currently taking and for what condition(s)? ____

____

____

Do you have any allergies? **YES / NO** List: ____

What vitamins/supplements are you currently taking? ____

Are you pregnant? **YES / NO** Due Date: ________________________

Please circle to indicate if you have experienced any of the following:

Headaches	Frequent colds	Menstrual problems	Concussion
Migraines	Thyroid problems	Difficulty getting pregnant	Dislocation
Sinus Problems	Throat problems	Vascular problems	Fracture
Dizziness	Asthma	Digestive problems	Leg pain
Vertigo	Difficulty breathing	Alzheimer's	Hip pain
Nausea	Chest pains	Memory loss	Wrist/hand pain
Earaches	Stroke	Insomnia	Ankle pain
Ringing in ears	Poor circulation	Cancer	Foot pain
Difficulty hearing	Heart problems	Diabetes	Shoulder pain
Vision problems	Skin problems	Hypertension	Low back pain
Nose bleeds	Easy bruising	Hypoglycemia	Mid back pain
Anxiety	Liver problems	Chronic cough	Neck pain
Depression	Kidney problems	Arthritis	Other joint pain
Nervousness	Fatigue	Scoliosis	Prostate problems

Other, please specify: ____

____

____

Family Health History:

Relation	Living	Deceased	Age (now or at death)	Illness/Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

Social/Work History:

Work Activity: **Sit** **Stand** **Computer Work** **Light Labor** **Heavy Labor**

Diet/Nutrition: Are you on any special diet? **YES / NO** If yes, for what reason? ______________________________

Have you gained or lost over 10 pounds in the past 6 months without wanting to? **YES / NO**

How many 8 ounce glasses of the following to you drink per day?

Water: ______ Soda: ______ Coffee: ______ Tea: ______ Energy Drinks: ______

Is your current weight a concern to you? **YES / NO**

Habits: Tobacco Use: Now? **YES / NO** Amount/Weekly_____ How long?_____ Years/Months

In the past? **YES / NO** Amount/Weekly______ How long?_____ Years/Months

Alcohol Use: Now? **YES / NO** Amount/Weekly______ How long?______ Years/Months

In the past? **YES / NO** Amount/Weekly______ How long?______ Years/Months

Review: **Rate each of these areas on a scale of 0 to 10**

Stress Level	No Stress	☺	1	2	3	4	5	6	7	8	9	10	☹	Very Stressed
Exercise	High Intensity	☺	1	2	3	4	5	6	7	8	9	10	☹	No Exercise
Daily Activity	Normal	☺	1	2	3	4	5	6	7	8	9	10	☹	Stuck In Bed
Sleep	Fully Rested	☺	1	2	3	4	5	6	7	8	9	10	☹	No Sleep
Appetite	Normal Appetite	☺	1	2	3	4	5	6	7	8	9	10	☹	Eat Nothing
Mood	Happy, Relaxed	☺	1	2	3	4	5	6	7	8	9	10	☹	Depressed

While we will work closely with you to resolve your chief complaint, as health care professionals we are also concerned about your overall wellness. On future visits we will discuss issues that may impact your overall health.

All of the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Wellness Way Chiropractic at this time:

____

Patient's Signature **Date**

____

Signature of Parent or Legal Guardian **Date**