Confidential Patient Health Record

Date:	I.D. NO.

PERSONAL HISTORY

Full Name: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: ____/____/_____ Age: _____ Sex: [ ] M [ ] F Marital Status: [ ] S [ ] M [ ] W [ ] D [ ] Sep

Employer: _____ Occupation: _____

Work Phone: _____ Emergency Contact: _____ Phone: _____

Relationship: _____ Referred To This Office By: _____

Payment / Insurance: [ ] Self [ ] Spouse [ ] Health Ins. [ ] Auto Ins. [ ] Worker's Comp [ ] Medicare

1. CURRENT CHIEF COMPLAINT & INJURY HISTORY

Primary Reason For Seeking Care:

_____

_____

_____

_____

When did this condition begin? ____/____/_____ Has it occurred before? [ ] Yes [ ] No

What caused the problem? [ ] Specific Incident [ ] Multiple Incidents [ ] Gradual Onset [ ] No Known Cause

Is this condition related to: [ ] Auto Accident [ ] Job Injury [ ] Home Injury [ ] Fall [ ] Other: _____

Date of Accident: ____/____/_____ Time: _____ [ ] AM [ ] PM Reported to Employer? [ ] Yes [ ] No

Have you seen other doctors for this? [ ] Yes [ ] No If yes, doctor name/results: _____

Previous treatment for similar symptoms? [ ] Yes [ ] No Where/When: _____

Progress of condition: [ ] Getting Better [ ] Getting Worse [ ] Staying the Same

What makes it BETTER? [ ] Nothing [ ] Lying down [ ] Walking [ ] Standing [ ] Sitting [ ] Movement
[ ] Inactivity [ ] Food

What makes it WORSE? [ ] Nothing [ ] Lying down [ ] Walking [ ] Standing [ ] Sitting [ ] Movement
[ ] Inactivity [ ] Food

2. PAST MEDICAL HISTORY & SURGERIES

Major Surgeries / Operations:

[ ] Appendectomy [ ] Tonsillectomy [ ] Gallbladder Removal [ ] Hernia Repair

[ ] Back Surgery [ ] Broken Bones [ ] Other Surgeries: _____

Major Accidents, Falls, or Illnesses NOT reported above: _____

Have you been tested for HIV positive? [ ] Yes [ ] No

Current Medications / Drugs:

[ ] Pain Killers / Muscle Relaxers [ ] Nerve Pills / Anti-anxiety [ ] Blood Pressure Medication

[ ] Insulin / Diabetes Medication [ ] Other: _____

Do you wear a shoe lift? [ ] Yes [ ] No

Daily Stress Level: [ ] No Stress [ ] Minimal [ ] Moderate [ ] Severe

Physical Activity at Work: [ ] Sit 50%+ [ ] Stand 50%+ [ ] Light Labor [ ] Heavy Labor

Regular Exercise Level: [ ] None [ ] Light [ ] Moderate [ ] Strenuous

Aspects of Life Affected: [ ] Home Life [ ] Work Life [ ] Recreation [ ] Sleep/Rest

Do you need assistance with everyday tasks? [ ] Yes [ ] No | Can you function without assistance? [ ] Yes [ ] No

Physical Restrictions / Work Status: _____

FEMALES ONLY:

Are you pregnant? [ ] Yes [ ] No [ ] Not Sure | Date of Last Menstrual Period: ____/____/_____

4. PAST DISEASE & LIFESTYLE CHECKLIST

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST:

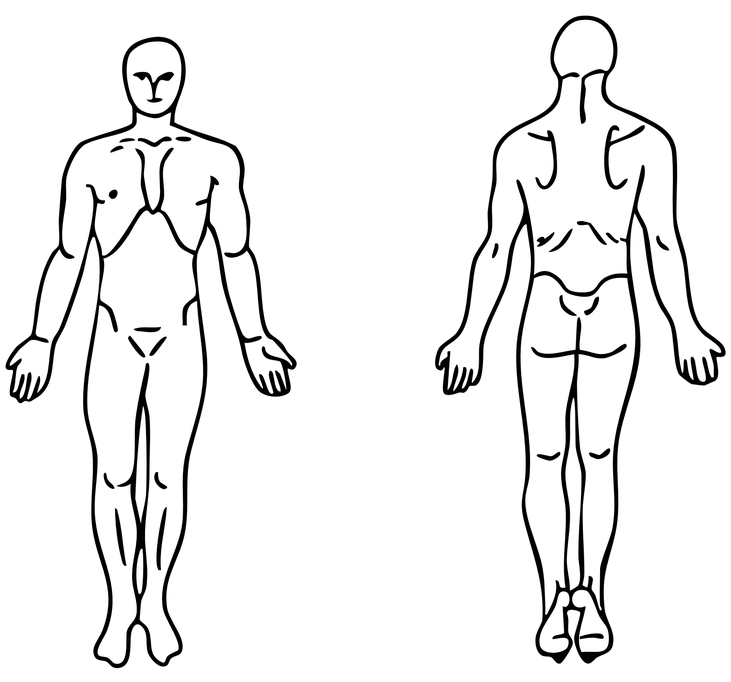
[ ] Heart Disease	[ ] High Blood Pressure	[ ] Diabetes	[ ] Thyroid Disease
[ ] Cancer / Tumor	[ ] Stroke	[ ] Kidney Disease	[ ] Asthma / Lung Conditions
[ ] Hepatitis / Liver	[ ] Anemia	[ ] Arthritis / Gout	[ ] Eczema / Skin Rash

LIFESTYLE INTAKE (Check if consumed regularly):

[ ] Coffee [ ] Tea [ ] Alcohol [ ] Cigarettes / Tobacco [ ] White Sugar

REGIONAL MUSCULOSKELETAL REVIEW

PLEASE MARK AREAS OF PAIN OR DISCOMFORT ON THE DIAGRAM BELOW:



HEAD, FACE & ENT

[ ] Lightheaded / Dizziness [ ] Memory Loss [ ] Stuffed Nose / Sinus Congestion
[ ] Fainting / Loss of Balance [ ] Double / Blurred Vision [ ] Face Numbness / Tingling
[ ] Head Feels Heavy [ ] Light Sensitivity [ ] TMJ Clicking or Popping
[ ] Hearing Loss / Ear Ringing [ ] Bloodshot Eyes [ ] Jaw Pain / Pain with Chewing
[ ] Sore Throat / Earaches [ ] Vision Problems [ ] Dental Problems / Clenching / Grinding

HEADACHE: [ ] Migraine [ ] Tension [ ] Pressure [ ] Throbbing [ ] Sinus
Frequency: Daily 1x/Wk 2x/Wk 3x/Wk __x/Wk __x/Mo | Location: Back of Head Forehead Temples
All Over Timing: Constant Frequent Intermittent Occasional | Severity: Mild Moderate Severe Dull Sharp
Burn Throb Pain Scale (0–10): _____

NECK

[ ] Pain [ ] Stiff [ ]Tight [ ]Tension
[ ] Ache [ ] Muscle Spasms [ ]Muscle Weakness [ ]Grinding / Grating
[ ] Jaw Tension [ ] Throat Tightness / Difficulty Swallowing
Location: Left Side Right Side Both Sides Base of Skull Nape of Neck Entire Neck
Aggravated By: Forward Movement Backward Movement Rotate Left Rotate Right Bend Left Bend Right
Timing: Constant Frequent Intermittent Occasional
Severity: Mild Moderate Severe Dull Sharp Burn Throb | Pain Scale (0–10): _____

CHEST & RESPIRATORY / CARDIOVASCULAR

[ ] Pain Between Ribs [ ]Pain in Breast Bone [ ] Shortness of Breath
[ ] Irregular Heartbeat / Palpitations [ ] Heart Problems / Angina [ ] Lung Conditions / Congestion
[ ] Chest Tightness / Pressure [ ]Pain with Deep Breathing [ ] Chronic Cough / Asthma
Timing: Constant Frequent Intermittent Occasional | Severity: Mild Moderate Severe | Pain Scale (0–10): _____

SHOULDERS

[ ] Pain Across Shoulders [ ] Shoulder Blade Pain [ ] Limitation of Motion
[ ] Joint Stiffness / Frozen Shoulder [ ] Popping / Catching in Joint
Location: Left Right Both | Timing: Constant Frequent Intermittent Occasional | Pain Scale (0–10): _____

ARMS & HANDS

Pain In: [ ]Upper Arm [ ]Elbow [ ] Forearm [ ] Wrist [ ] Hand (L / R / Both)
Pins & Needles In: [ ]Arm [ ]Hand (L / R / Both)
Numbness In: [ ] Arm [ ] Hand (L / R / Both)
Weakness In: [ ] Arm [ ]Grip / Hand (L / R / Both)
Timing: Constant Frequent Intermittent Occasional | Severity: Mild Moderate Severe | Pain Scale (0–10): _____

LEGS & FEET

[ ] Joint Pain / Stiffness [ ]Pain Radiates Down Leg to: [ ] Mid-Thigh [ ] Knee [ ] Calf [ ] Foot (L / R / Both)
Pins & Needles In: [ ]Leg [ ]Foot (L / R / Both)
Numbness In: [ ]Leg [ ]Foot (L / R / Both)
[ ] Ankle Pain [ ] Swollen Ankle / Foot [ ]Foot Pain
[ ] Muscle Cramps [ ] Varicose / Spider Veins [ ]Cold Feet or Toes
[ ] Restless Legs [ ] Walking Problems / Unsteadiness
Timing: Constant Frequent Intermittent Occasional | Severity: Mild Moderate Severe | Pain Scale (0–10): _____

GENERAL WELLNESS & MOOD

[ ] Anxiety / Nervousness [ ]Irritability / Tension [ ] Confusion / Depression
[ ] Disturbed / Loss of Sleep [ ]Fatigue / Low Energy [ ] Forgetfulness / Inability to Concentrate
[ ] Apprehension / Stress
Timing: Constant Frequent Intermittent Occasional | Severity: Mild Moderate Severe

FAMILY HISTORY

Have any immediate family members experienced similar health problems?
[ ] Mother [ ] Father [ ] Brother [ ] Sister [ ] Spouse [ ] Child

AUTHORIZATION & SIGNATURE

I hereby authorize the Doctor to treat my condition as she deems appropriate. The information I have provided is complete and accurate to the best of my knowledge.

Patient Signature: _____ Date: ____/____/_____

Guardian / Spouse Signature (if minor): _____ Date: ____/____/_____