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Confidential Health Record

Welcome To Our Office! Today's Date M/D/Y ___/___/___

Whom may we thank for referring you to our office? _____

Personal Information

Name LAST _____ FIRST _____ MIDDLE _____

Birth Date M/D/Y ___/___/___ Age _____ Sex PLEASE CHECK ● Male ● Female Social Security # _____-_____-_____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone # HOME _____ CELL _____ WORK _____

Email Address _____ Occupation _____

Marital Status PLEASE CHECK ● Single ● Married ● Widowed ● Divorced ● Separated

Spouses Name LAST _____ FIRST _____ # of Children _____

Why Upper Cervical Chiropractic?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Your doctor will weigh your needs and desires when recommending your program of care. PLEASE CIRCLE THE TYPE OF CARE THAT BEST MEETS YOUR NEEDS:

Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting.

Emergency Contact

Name LAST _____ FIRST _____ Relationship ● Spouse ● Relative ● Friend

Phone # HOME _____ CELL _____ WORK _____

Present Health Challenge

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR **CHIROPRACTIC WELLNESS SERVICES**, CHECK HERE ●

Unwanted Health Challenge

Explain why you are here today _____

_____

_____

_____

_____

Has it ever occurred before? ● Yes ● No

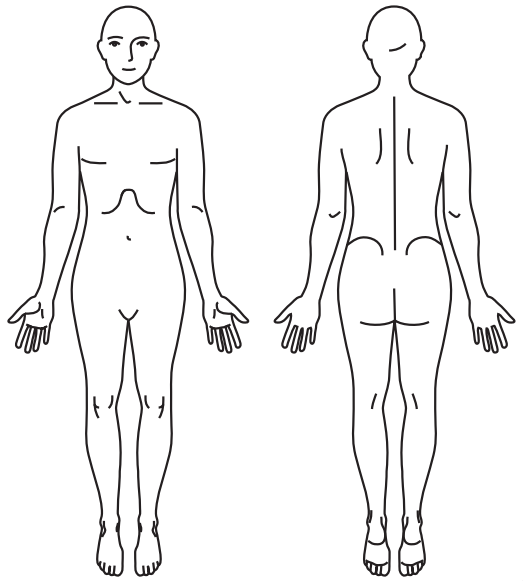
When do you think these problems originally started? _____

_____

_____

Date of Auto Crash or Work Related Injury M/D/Y ___/___/___

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE BLANKS.

Body Area(s) Involved ● Neck ● Back ● Head ● Other _____

Mechanism of Onset ● Auto ● Work ● Slip/Fall ● Other _____ Onset Date M/D/Y ___/___/___

Current Symptoms ● Pain ● Numbness ● Stiffness ● Weakness ● Other _____

Quality ● Burning ● Diffuse ● Dull/Aching ● Localized ● Radiating ● Sharp ● Shooting ● Stabbing ● Throbbing ● Tightness ● Tingling ● Other _____

Timing ● Morning ● Afternoon ● Night ● With Activity ● Constant ● Intermittent

What Makes it Worse? _____

What Makes it Better? _____

Level of Impairment Due to Symptoms CIRCLE THE APPROPRIATE LEVEL WITH **0 = NONE / 10 = EXTREME**

While Resting	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10

Headaches

Location ● Occipital ● Frontal ● Left Temporal ● Right Temporal ● Parietal ● Sinus

Quality ● Dull ● Sharp ● Throbbing ● Stabbing ● Aura ● No Aura

Types ● Hat Band ● Cluster ● Migraine ● Tension

Employment – Occupation/Job Title _____ Work # _____ hours per day

Conditions Effect on Job Performance ● No Effect ● Mild Pain ● Moderate Pain ● Unable to Perform

Daily Activities – Effects of Current Condition on Performance

Bending	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Change Position (Sit-Stand)	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Climb Stairs	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Driving	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Extended Computer Use	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Household Chores	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Lifting	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Reading/Concentration	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Self Care (Bathe/Dress)	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Sexual Activities	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Sleep	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Prolonged Sitting	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Prolonged Standing	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)
Walking	● No Effect	● Mild (Can do)	● Moderate (Limited)	● Severe (Unable to Perform)

HEALTH HISTORY FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

Previous Chiropractic Care: ● I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name _____ Date of Last Visit M/D/Y ___/___/___

Current Medication(s) LIST **ANY/ALL** MEDICATIONS YOU ARE **CURRENTLY** TAKING. BE SPECIFIC. _____

_____

Doctor's Name _____

Illness(es) **LIST** ALL HEALTH CONDITIONS. _____

_____

Surgery(ies) **LIST** ALL SURGICAL PROCEDURES. WRITE THE **DATE** OF THE PROCEDURE IMMEDIATELY AFTERWARD. _____

_____

Injury(ies) MARK OR LIST ALL INJURIES. WRITE THE **DATE** OF THE INJURY IMMEDIATELY AFTERWARD.

● Fall (Severe) M/D/Y ___/___/___ ● Broken Bones M/D/Y ___/___/___ ● Loss of Consciousness M/D/Y ___/___/___

● Head Injury M/D/Y ___/___/___ ● Back/Neck Injury M/D/Y ___/___/___ ● Motor Vehicular Crash M/D/Y ___/___/___

THANK YOU FOR ALLOWING US TO SERVE YOU!