

Confidential Patient Health Record

Date: ___/___/___

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ___/___/___ Age: ___
First: _____ Middle: _____ Last: _____ Gender: Male / Female
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____ Fax #: (____) _____ - _____
Driver's License #: _____ State: _____ Email Address: _____
Spouses Name: _____
Ages of Children: _____

Employer

Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (____) _____ - _____ Type of Work: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Phone Number: (____) _____ - _____
Address: _____
Relationship: _____

Who Is Responsible For Your Bill?

Self Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: _____ - _____ - _____ Pharmacy: _____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

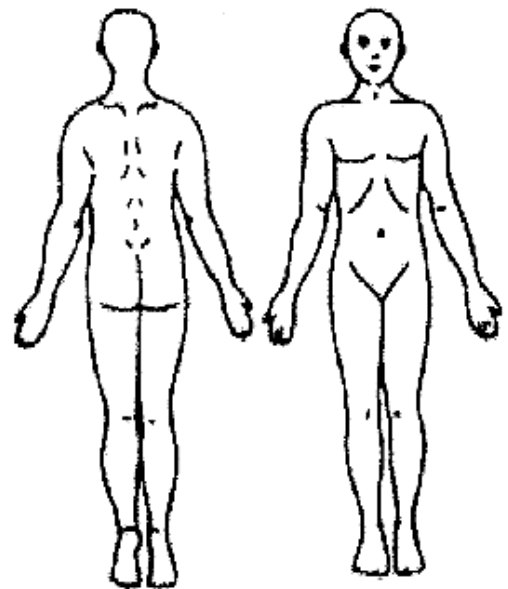
PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ___/___/___
Has it ever occurred before? Yes No
When? _____
Is the condition: Auto Related Work Related
 No Injury Other

Explain: _____

Date of Accident: _____
Time of Accident: _____
Complaint/Pain Onset Date: _____
If Work Related:
Have you filed an injury report with your employer? Yes No
Claim #: _____



Have you seen other doctors for this condition? Yes No If yes, Who? (Name) _____

Location of Office: _____ Type of Treatment: _____

Were you satisfied with the results of your treatment? Yes No Explain: _____

Are you currently taking any prescription medications? Yes No. If yes, please mark or list below (be specific).

Allergy Medication Anti-Depressants Blood Pressure Medication Insulin Muscle Relaxers

Nerve Pills Pain Killers Other (please be specific): _____

Do you wear any of the following? Yes No. If yes, please mark: Heel Lifts Innersoles Arch Supports Orthotics

Please list any other conditions you feel we should know about – even if unrelated: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all of the sections, even if “DENY”.

Constitutional: I... Deny Any Constitutional Issue (s)

Chills Daytime Somnolence (Drowsiness) Fatigue Fever Night Sweats
 Weight Gain Weight Loss

Eyes/Vision: I... Deny Any Eyes/Vision Issue (s)

Blindness Blurred Vision Cataracts Change in vision Double Vision
 Eye Pain Field Cuts (visual field defect) Glaucoma Itching (around the eyes) Photophobia
 Tearing Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I... Deny Any Ears, Nose and Throat Issue (s)

Bleeding Dental Implants Dentures Difficulty Swallowing Discharge
 Dizziness Ear Drainage Ear Infection(s) Ear Pain Fainting
 Headaches Head Injury (history of) Hearing Loss Hoarseness Loss of Smell
 Nasal Congestion Nose bleeds (frequent) Post Nasal Drip Rhinorrhea (Runny nose) Sinus Infections
 Snoring Sore Throats (frequent) Tinnitus (Ringing in Ears) TMJ problems

Respiration: I... Deny Any Respiratory Issue (s)

Asthma Cough Coughing up blood Shortness of Breath Sputum Production Wheezing

Cardiovascular: I... Deny Any Cardiovascular Issue (s)

Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur
 Heart Problems Orthopnea (difficulty breathing while lying down) Palpitations (irregular or forceful beating of the heart)
 Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) Shortness of Breath with Exertion or Exercise
 Swelling of Legs Ulcers Varicose Veins

Gastrointestinal: I... Deny Any Gastrointestinal Issue (s)

Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea
 Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin)
 Nausea Rectal Bleeding Abnormal Stool Caliber (quality) Abnormal Stool Color
 Abnormal Stool Consistency Vomiting Vomiting Blood

Female: I... Deny Any Female Issue (s)

Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination
 Hormone Therapy Irregular Menstruation Urine Retention Vaginal Bleeding Vaginal Discharge

Male: I... Deny Any Male Issue (s)

Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Problems
 Urine Retention

- Endocrine: I... Deny Any Endocrine Issue (s)
- Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst
 - Frequent Urination Goiter Hair Loss Heat Intolerance Unusual Hair Growth
 - Voice Changes

- Skin: I... Deny Any Skin Issue (s)
- Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss Hives Itching
 - Paresthesia (numbness, prickling, or tingling) Rash History of Skin Disorders Skin Lesions/Ulcers Varicosities

- Nervous System: I... Deny Any Nervous System Issue (s)
- Dizziness Facial Weakness Headaches Limb Weakness Loss of Consciousness
 - Loss of Memory Numbness Seizures Sleep Disturbance Slurred Speech
 - Stress Strokes Tremors Unsteadiness of Gait

- Psychologic: I... Deny Any Psychologic Issue (s)
- Anhedonia (inability to experience joy or enjoy life) Anxiety Appetite Changes Behavioral Change(s)
 - Bipolar Disorder Confusion Convulsions Depression Insomnia Memory Loss
 - Mood Change(s)

- Allergy: I... Deny Any Allergy Issue (s)
- Anaphylaxis (history of) Food Intolerance Itching Nasal Congestion Sneezing

- Hematology: I... Deny Any Hematologic Issue (s)
- Anemia Bleeding Blood Clotting Blood Transfusion(s) Bruises easily Fatigue Lymph Node Swelling

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

- Childhood Illness: I... Deny Any Childhood Illness (es)
- ADD Allergies/Hayfever Asthma Atopic Dermatitis (Eczema) Bedwetting
 - Cerebral Palsy Chicken Pox Depression Diabetes Ear Infections
 - Fetal Drug Exposure Food Allergies Headaches Hepatitis HIV
 - Measles Mumps Rash Scoliosis Seizure Disorder
 - Sickle Cell Anemia Spina Bifida Other (please describe): _____

- Adult Illness: I... Deny Any Adult Illness (es)
- Alzheimers Anemia Arthritis Asthma Cancer
 - Chicken Pox Crohn's/Colitis CRPS (RSD) CVA (stroke) Cystic Kidney Disease
 - Depression Diabetes (Insulin) Diabetes (Non insulin) Ear Infections (frequent) Emphysema
 - Eye Problems Fibromyalgia Heart Disease Hepatitis HIV
 - Hypertension Influenzal Pneumonia Liver Disease Lung Disease Lupus Erythema (discoid)
 - Lupus Erythema (systemic) Multiple Sclerosis Parkinson's Disease Pleurisy Pneumonia
 - Psychiatric Problems Scoliosis Seizure Disorder Shingles STD's (unspecified)
 - Suicide Attempt(s) Thyroid Problems Vertigo
 - Past history of similar symptoms to your current condition Other Illness (please be specific): _____

- Surgeries: I... Deny Any Surgery (ies)
- Angioplasty Appendectomy Caesarian Section Cardiac Catheterization Carpal Tunnel Repair
 - Coronary Artery Bypass Cosmetic D & C Dental Surgery Gallbladder
 - Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction Joint Replacement
 - Laminectomy Mastectomy Pacemaker Insertion Rotator Cuff Spinal Fusion
 - Tonsilectomy Other (please be specific): _____

- Ob/Gyn: I... Deny Any Ob/Gyn Issue (s)
- I... have never been pregnant have been pregnant in the past am currently pregnant
- _____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
- _____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
- _____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____
 My menses is Regular Irregular; I am currently in Metaphase Menopause; Date of Last Menses ____/____/____

Injuries: I... Deny Any Injury (ies)
 Back Injury Broken Bones Severe Fall Fracture Disability
 Head Injury Industrial Accident Joint Injury Severe Laceration Motor Vehicle Accident
 Mild/Moderate Soft Tissue Injury Severe Soft Tissue Injury

Immunizations: I... Deny Any Immunization (s)
 DTaP(diphtheria, tetanus, and pertussis) Flu Hepatitis A Hepatitis B Hepatitis C
 Influenza IPV (Polio) MMR (measles, mumps, and rubella) Pneumococcal
 PPD (Mantoux Test-TB) Small Pox TB Varivax (chicken pox) Whooping Cough (Pertussis)

Non-Drug Allergies: I... Deny Any Non-Drug Allergy (ies)
 Animals Dairy Eggs Food Coloring Mold Pollen Wheat
 Other (please be specific): _____

Family History		Condition (please be specific)
General Family	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Paternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Paternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Maternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Maternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Son (s)	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Daughter (s)	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Brother (s)	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____
Sister (s)	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased; <input type="checkbox"/> Normally Developed <input type="checkbox"/> No Significant Disease <input type="checkbox"/> Has/Had:	_____

Social History
 Alcohol: Never Social Consumption only Beer Liquor Wine ; _____oz _____glasses; Day Week Month
 Diet (please mark all that apply): High Fat High Fiber High Protein High Salt
 Low Calorie Low Carb Low Fiber Low Salt Low Sugar
 Education (please mark the highest level completed): Preschool Elementary Middle Junior High Votech
 In High School Did Not Finish High School High School Diploma Post High School Classes Assoc/Technical Degree
 In College College Degree In Graduate School Graduate Degree Doctorate Other: _____
 Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____ Have used drugs for _____
 Tobacco: Deny Tobacco Use Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
 Smoke; # _____per Day Week Month Chew; # _____cans per Day Week Year



PATIENT-DOCTOR AGREEMENTS

The purpose of this agreement is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

WHAT TO EXPECT FROM US . . .

- A. We will be your partner in health
- B. If we are unable to help you, we will direct you to someone who can
- C. State-of-the-art care and timely appointments
- D. Free nerve scan for your entire family

VISIT EXPECTATIONS (TO MAKE APPOINTMENT EFFICIENT)

- 1. Verbally check in at the front desk.
- 2. If you are waiting longer than 20 minutes in the hospitality area, please report to the front desk.
- 3. If you use the Pro-Adjuster, please remove belts, necklaces and hooded sweatshirts.
If you use the Thompson Table, please remove necklaces, earrings, hooded sweatshirts and items in pockets.
- 4. Schedule future visits in advance.

SPINAL REJUVENATION WORKSHOP

It is required that all patients attend our Spinal Rejuvenation Workshop within two weeks of your initial visit. The workshop is a group presentation in which one of our Doctors will teach you what you can do to help yourself make healthy lifestyle choices. We will discuss exercise, posture, nutrition...things that you can do on your own! The fee for this workshop is included in your initial visit and is held at our clinic on Tuesday evenings at 7:00.

We strongly recommend that you bring your partner in health.

We have scheduled you for class on the following date _____

PAYMENT OF BILLS

- Any deductible or co-pay must be paid prior to service. They may also be paid ahead weekly or monthly prior to visits.
- Any insurance checks sent to your home by the insurance company must be brought to our office within 3 days. Attach a copy of the payment stub which indicates which services were paid.
- If your insurance company is not responding to our claims in a timely manner (60 days) you will be asked to call and/or write them to assist with collections for services rendered.
- If your insurance company deems that services are not medically necessary or not covered under your plan, you will be responsible for any unpaid balance.

There is a \$25 processing fee added to any account for any returned check. We do accept payment by Visa, MasterCard, American Express and Discover.

MISSED APPOINTMENTS

If for any reason you cannot keep an appointment, we require that you telephone immediately. If you miss an appointment without a two (2) hour notice, our office reserves the right to charge for that missed appointment. There will be a service charge of \$20 upon the 4th missed appointment and all future occurrences. If you need to change your appointment, contact the office in advance to do so. It is your obligation to make up a missed appointment within 7 days of any cancellation.

CELL PHONES

Out of respect for you and other patients in the office, we ask that you please turn off cell phones upon entering our office.

EMERGENCY NUMBERS

In case of chiropractic emergencies such as flare-ups, falls or injuries, please call our office at 502-863-3520. If it is an after hours chiropractic emergency, your doctors are listed in the phone book however, after hours charges do apply. If it is a medical emergency, contact your medical doctor.

RESULTS

Your results are positively influenced by adhering to our recommendations. If you are unhappy with your results, we respectfully request that you share your feelings so that we may resolve any of your concerns.

I have read this outline and I understand and accept these policies:

Patient name (please print) _____

Patient Signature _____ Date _____

Patient cell phone number _____

Patient email address _____

CA Signature _____