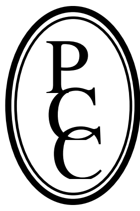


PATTERSON CHIROPRACTIC CENTER

NEW PATIENT CONFIDENTIAL HEALTH RECORD

Name (Last)____________ (First)____________ (Middle)____________ Date _________

Address ____________________ City ____________ State _____ Zip ________

Age _____ Birth Date ________ Marital S M D W Sex M F SS #_________ Spouse's Name __________

Home # (___) ________ Work # (___) ________ Cell # (___) ________ E Mail ____________

Patient's Employer ____________________ Job ____________

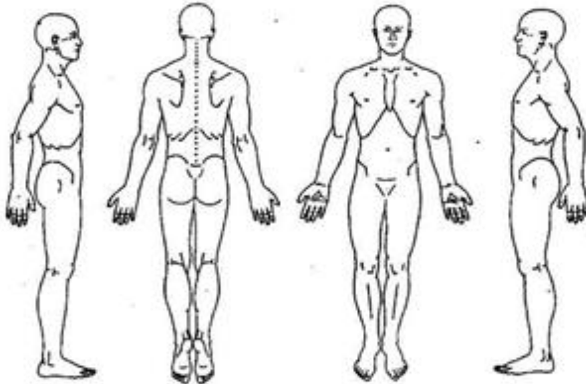
Address ____________________ Work # (_______)__________

Insurance Co. ____________ Group# ________ ID # __________

Name of Insured ____________ Birth Date ________ SS # __________

Insured's Employer ____________________ Work # (_______)__________

Relation to Insured ____________ Referred by ____________________



Please outline and shade where you have pain or other symptoms

When did your symptoms start? ____________

How did your symptoms begin? ____________

____

____

1. PRIMARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine ________

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

2. SECONDARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine ________

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

3. ADDITIONAL conditions:

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine ________

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the :
___ Morning ___ Afternoon __ Evening

Have you seen another doctor for your CURRENT condition(s)? ___ No ___ Yes When________________________________

Have you had previous tests or studies for your CURRENT condition(s)? ___ No ___ Yes When________________________________

Have you had previous medications or care for your CURRENT condition(s)? ___ No ___ Yes When________________________________

Have you lost time from work due to this CURRENT problem? ___ No ___ Yes When________________________________

Have you had SIMILAR symptoms in the past? ___ No ___ Yes When________________________________

Have you had Chiropractic care before? ___ No ___ Yes When________________________________

To your knowledge, are you pregnant? ___ No ___ Yes

Are you taking birth control medicines? ___ No ___ Yes

Are you seeing an OB-GYN doctor regularly? ___ No ___ Yes Name________________________________

Your Past History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Grandparents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Parents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Siblings' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems

Current Medications:	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**
	______________________	______________________	______________________
	______________________	______________________	______________________
	______________________	______________________	______________________

Your Social History:	__ Never Smoked	__ Former Smoker	__ Current Smoker
	__ No Alcohol	__ Drink Alcohol	__ No Recreational Drugs
Allergies:	__ Sinus / Respiratory	__ Food / Digestion	__ Skin
	__ Prescription Medicine (Names Allergic To)________________________________		

Surgeries/Hospitalized:	Type/area____________________________	Surgeon________________________	When?______________
	Type/area____________________________	Surgeon________________________	When?______________
	Type/area____________________________	Surgeon________________________	When?______________
	Type/area____________________________	Surgeon________________________	When?______________

In general, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
Compared to a year ago, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
Decrease of social activities during the past 4 weeks:	__ Not at all	__ Slightly	__ Moderately	__ Quite a bit	__ Extremely

General:	__ Fatigue	__ Weakness	__ Fever / Chills	__ Weight Change	__ Night Sweats
Skin:	__ Pain	__ Rash	__ Redness	__ Itching	__ Eczema
Eyes:	__ Pain	__ Discharge	__ Infection	__ Vision Trouble	
Ears:	__ Pain	__ Discharge	__ Infection	__ Hearing Trouble	__ Ringing
Nose:	__ Pain	__ Bleeding	__ Infection	__ Absence of smell	__ Obstruction
Mouth/Throat:	__ Pain	__ Bleeding	__ Gum Disease	__ Abnormal Taste	__ Lesions
Heart:	__ Pain	__ Palpitations	__ Edema/ Swelling	__ Murmur	__ Fainting
Lungs:	__ Pain	__ Cough	__ Phlegm	__ Difficult breathing	__ Bloody Discharge
Gastrointestinal:	__ Pain	__ Nausea	__ Diarrhea	__ Constipation	__ Weight Change
Genitourinary:	__ Pain	__ Discharge	__ Blood in Urine	__ Incontinence	__ Frequent Urination
	__ Sterility	__ Impotence	__ Abnormal Bleeding	__ Amenorrhea	
Endocrine	__ Hair Loss	__ Thirsty	__ Tremors	__ Hot/cold intolerance	__ Sleep issues
Neurological:	__ Headaches	__ Seizures	__ Dizziness	__ Numbness	

APPLICATION FOR TREATMENT

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction

Are you interested in improving your overall health? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me and charged to me are my responsibility to be paid to the doctor. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE ______________________________ **DATE** ______________

GUARDIAN'S SIGNATURE ______________________________ **DATE** ______________