Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ State/Prov: __________ Zip/Postal Code: __________

Home Phone: ______________________ Birth Date: __________ Age: ________ Sex: ☐ M ☐ F

Cell Phone: ______________________ E-mail Address: ______________________

Social Security # ______________________ Driver's License Number: ______________________

Social Insurance # ______________________ Circle One: Married Single Widowed Divorced Separated

Business Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________ Spouse's Social Security # ______________________

Name of Spouse ______________________ Spouse's Social Insurance # ______________________

Spouse's Employer ______________________ Business Phone ______________________

Type of Work ______________________ Name and Ages of Children ______________________

Referred To This Office By: ______________________ ______________________

Name and Number of Emergency Contact: ______________________ Relationship: ______________

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) ______________________ ☐ Health Card # ______________

Insured Person's Name ______________________ Date of Birth ______________

CURRENT HEALTH CONDITION

Unwanted Health Condition ______________________

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? ______________________

Type of Treatment: ______________________ Results: ______________________

When Did This Condition Begin? ______________________ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: ______________

Date of Accident: ______________________ Time of Accident: ______________________

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other ______________________

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? ______________

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PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other ______________________

Major Accident or Falls: ______________________

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Hospitalization (Other Than Above): ______________________

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Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit ______________