Confidential Patient Health Record

Today's Date: ___/___/______

How did you hear about us? ☐ Family/Friend ______________ ☐ Dr. ______________
☐ Close to home/work ☐ Yellowbook ☐ Verizon Superpages ☐ EZ to Use ☐ Internet ☐ Drove By

Personal Information

Last: ______________ First: ______________ Middle: ______________

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III

Birth Date: ___/___/_____ Age:_____ Sex: Male / Female SSN: ______________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: ______________________________ Apt # _____

City: ______________ State: _____ Zip: ________ Country: ______________ County: ____________

Home Phone: (______) ______-________ ext _____ Work Phone: (______) ______-________ ext _____

Cell Phone: (______) ______-________ ext _____ Fax #: (______) ______-________ ext _____

Email Address: ______________________ Spouses Name: ______________________

Appointment Reminder? Please choose an option: ☐ Text Message ☐ Email ☐ No reminder, please

Please circle how soon before your scheduled appointment that you would prefer to receive your reminder:

2 hours 4 hours 1 day

If you chose TEXT MESSAGE APPOINTMENT REMINDER, please circle your cell phone provider:

AT&T; Boost Mobile; Cricket; MetroPCS; Nextel; Sprint; T-Mobile; US Cellular; Verizon; or Virgin Mobile

Emergency Contact

Last: ______________ First: ______________ Middle: ______________

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other ______________

Home Phone: (______) ______-________ ext _____ Cell Phone: (______) ______-________ ext ___

Work Phone: (______) ______-________ ext _____

Insurance Information:

Primary Health Insurance: ______________ Secondary Health Insurance: ______________

Policy Holder's Name: ______________ Primary Care Physician: ______________

Policy Holder's Date of Birth: _____-_____-______ PCP's Phone Number: ______________

Workers Compensation Injury/Auto/Personal Injury:

Have you filed an injury report with your employer? ☐ Yes ☐ No Date: ___/___/_____ Time: ______ am/pm

Carrier: ______________________ Policy # ______________

Carriers Phone #: (______) ________-__________ Adjuster: ______________

Claim #: ____

I acknowledge that I have received Logan Valley Chiropractic's Notice of Privacy Practices for protected health information.

Patient Print Name: ______________________ Date: __________

Patient's Signature: ______________________ Date: __________

Revised 11/2014
Desktop/Patient Health Record

Patient Name: ______________________ Date: ______________

REVIEW OF SYSTEMS - **Below is a list of symptoms 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.**

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

- ☐ chills
- ☐ daytime drowsiness
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ blindness
- ☐ blurred vision
- ☐ cataracts
- ☐ change in vision
- ☐ double vision
- ☐ eye pain
- ☐ field cuts
- ☐ glaucoma
- ☐ itching
- ☐ photophobia
- ☐ tearing
- ☐ wear glasses/contacts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ bleeding
- ☐ dentures
- ☐ difficulty swallowing
- ☐ discharge
- ☐ dizziness
- ☐ ear drainage
- ☐ ear pain
- ☐ fainting
- ☐ frequent sore throats
- ☐ headaches
- ☐ hearing loss
- ☐ history of head injury
- ☐ hoarseness
- ☐ loss of sense of smell
- ☐ nasal congestion
- ☐ nosebleeds
- ☐ postnasal drip
- ☐ rhinorrhea (runny nose)
- ☐ sinus infections
- ☐ snoring
- ☐ sore throat
- ☐ tinnitus (ringing in ears)
- ☐ TMJ problems

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ asthma
- ☐ cough
- ☐ coughing up blood
- ☐ shortness of breath
- ☐ sputum production
- ☐ wheezing

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ angina (chest pain or discomfort)
- ☐ chest pain
- ☐ claudication (leg pain/ache)
- ☐ heart murmur
- ☐ heart problems
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ orthopnea (difficulty breathing lying down)
- ☐ palpitations
- ☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)
- ☐ shortness of breath with exertion or exercise
- ☐ swelling of legs
- ☐ ulcers
- ☐ varicose veins

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ abdominal pain
- ☐ belching
- ☐ black - tarry stools
- ☐ constipation
- ☐ diarrhea
- ☐ difficulty swallowing
- ☐ heartburn
- ☐ hemorrhoids
- ☐ indigestion
- ☐ jaundice
- ☐ nausea
- ☐ rectal bleeding
- ☐ abnormal stool caliber
- ☐ abnormal stool color
- ☐ abnormal stool consistency
- ☐ vomiting
- ☐ vomiting blood

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

- ☐ birth control
- ☐ breast lumps/pain
- ☐ burning urination
- ☐ cramps
- ☐ frequent urination
- ☐ hormone therapy
- ☐ irregular menstruation
- ☐ pregnancy
- ☐ urine retention
- ☐ vaginal bleeding
- ☐ vaginal discharge

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ burning urination
- ☐ erectile dysfunction
- ☐ frequent urination
- ☐ hesitancy/ dribbling
- ☐ prostate problems
- ☐ urine retention

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

- ☐ cold intolerance
- ☐ diabetes
- ☐ excessive appetite
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ abnormal frequency of urination
- ☐ goiter
- ☐ hair loss
- ☐ heat intolerance
- ☐ unusual hair growth
- ☐ voice changes

Patient Name: ______________________ Date: ____________

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture ☐ hair loss ☐ itching ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ paresthesias ☐ varicosities
☐ hair growth ☐ history of skin disorders ☐ rash

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor
☐ facial weakness ☐ loss of consciousness ☐ seizures ☐ stress ☐ unsteadiness of gait/ loss of balance
☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia ☐ behavioral change ☐ convulsions ☐ memory loss
☐ anxiety ☐ bi-polar disorder ☐ depression ☐ mood change
☐ loss or change in appetite ☐ confusion ☐ insomnia

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphalaxis ☐ itching ☐ chronic nasal congestion ☐ sneezing
☐ food intolerance ☐ acute nasal congestion ☐ rash

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia ☐ blood clotting ☐ bruising easily ☐ lymph node swelling
☐ bleeding ☐ blood transfusion ☐ fatigue

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

Previous Care for Same Condition: ☐ **I have not seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. **If yes, Who?** (Name) ____________
Type of Treatment: ____________ **Was the treatment beneficial in resolving condition?** ☐ Yes ☐ No

Explain: ______________________________

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

Doctor's Name: ____________ **Location:** ____________ **Date of Last Visit:** ________

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD ☐ chicken pox ☐ headaches ☐ scoliosis
☐ atopic dermatitis (eczema) ☐ crohn's/colitis ☐ hepatitis ☐ seizure disorder
☐ allergies/hayfever ☐ depression ☐ HIV ☐ sickle cell anemia
☐ anemia ☐ diabetes ☐ measles ☐ spina bifida
☐ asthma ☐ ear infections ☐ mumps ☐ other:
☐ bedwetting ☐ fetal drug exposure ☐ psoriasis
☐ cerebral palsy ☐ food allergies (list below) ☐ rash

Patient Name: ______________________________ Date: ______________

Adult Illness(es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ alzheimers	☐ depression	☐ influenzal pneumonia	☐ scoliosis
☐ anemia	☐ diabetes (insulin dep)	☐ liver disease	☐ seizures
☐ arthritis	☐ diabetes (non insulin)	☐ lung disease	☐ shingles
☐ asthma	☐ eczema	☐ lupus erythema (discoid)	☐ past history of similar symptoms
☐ cancer	☐ emphysema	☐ lupus erythema (systemic)	☐ STD's (unspecified)
☐ cerebral palsy	☐ eye problems	☐ multiple sclerosis	☐ suicide attempt(s)
☐ chicken pox	☐ fibromyalgia	☐ parkinson's disease	☐ thyroid problems
☐ crohn's/colitis	☐ heart disease	☐ unspecified pleural effusion	☐ vertigo
☐ CRPS (RSD)	☐ hepatitis	☐ pneumonia	☐ other:
☐ CVA (stroke)	☐ HIV	☐ psoriasis	

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: ______________
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ 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: ____________

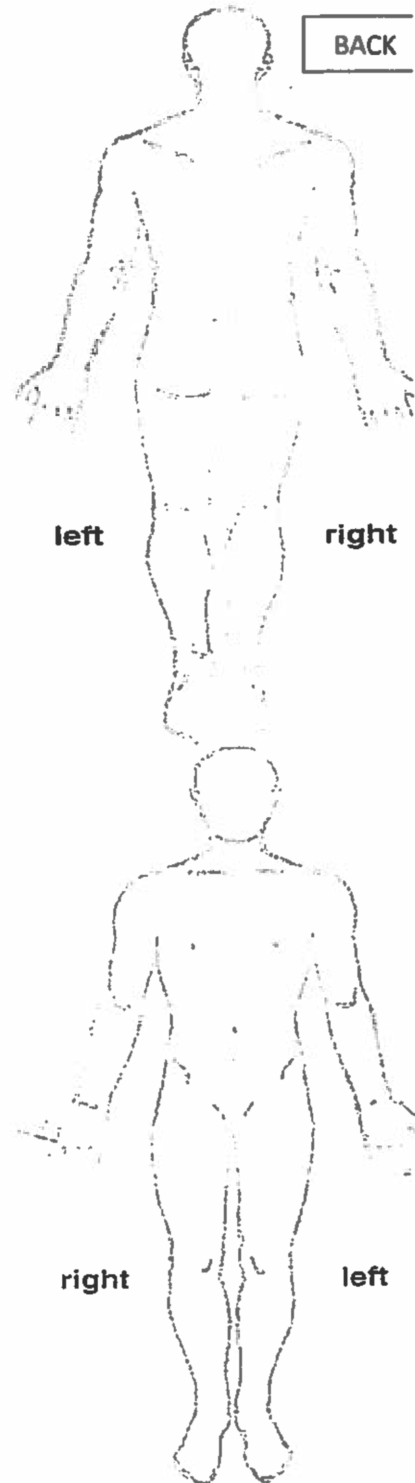
Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since _________ ☐ Have used drugs for ________

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 Name ______________________________ Today's Date ____/____/____

Occupation ______________________________ Date of Birth ____/____/____

☐ **Just seeking general wellness and prevention, no significant problem (SKIP THIS PAGE Go to Page 2)**



1. **Primary Complaint**______________________________
2. **Are you currently treating with an MD for this condition? YES NO**
3. **Location: Show on the diagram the location of the pain / problem or discomfort with a #1. If it is radiating or moving into another area show with an arrow.**
4. **Quality: How would you describe the pain or symptom? (Circle all that apply)**
   Aching Burning Cramping Diffuse Dull Excruciating Numbness
   Pounding Pulsating Radiating Sharp Shooting Stabbing Stiffness
   Throbbing Tingling Tightness Weakness
5. **Severity:** On a scale from 0 to 10, with 10 being the worst possible, how would you rate your pain or problem NOW?
   (0 = no pain, 1-3 = mild, 3-7 = Moderate, 7-10 = Severe)

Now	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

6. **How long ago did it start?**__________ **days, weeks, months, years ago**
   OR DATE ____/____/____
   How did it start? ______________________________
   ____
7. **How often are you experiencing it? (Circle one)**
   Infrequently (less than daily) **Occasionally** (1/4 of the time) **Intermittently** (1/2 of the time) **Frequently** (¾ of the time) **Constantly** (90-100%)
8. **What makes it worse? (Circle all that apply)**
   Pushing Pulling Movement Driving Bending Sitting Standing Lifting
   Kneeling Lying Down Coughing Sneezing Nothing Weight Bearing
   Looking up Looking Down Walking Other: ______________
9. **What makes it better? (Circle all that apply)**
   Activity Heat Ice Elevation Massage Standing Walking Resting Pain Meds
   Sitting Stretching Movement Immobilization Nothing Other: __________
10. **Describe any other symptoms related to this problem:**______________
11. **Prior Treatment-What have you done for this problem so far? (Circle)**

    Rest Heat Ice Massage Pain Meds Traction Exercise Hot Showers
    Ointment Inactivity Sitting Chiropractic Nothing Helps
    Other______________________________

    Did you get any relief? NO SOME TEMPORARY

    Have you seen another Chiropractor? Who? ____________When? ________

REQUIRED FOR INSURANCE

What *Normal Activity* do you have trouble with as a result of your problem?

____

****IMPORTANT****

If you have a Secondary specific complaint ask for another Patient History

Patient Name: ______________________________ **Date:** ______________

Daily Activities: Effects of Current Condition on Performance: MARK ONLY THE ONES THAT APPLY

Activity	Mild	Moderate	Severe
Bending	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Care-Infirm Family	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Carrying Groceries	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Change Position/Sit-Stand	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Climb Stairs	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Driving	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Extended Computer Use	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Feeding	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Household Chores	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Kneeling	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Lifting Children	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Lifting	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Pet Care	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Reading (Concentration)	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Self Care	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Self Care-Bathing	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Self Care-Dressing	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Self-Care Shaving	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Sexual Activities	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Sleep	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Static Sitting	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Static Standing	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Standing Walking Recreation	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform
Yard Work	◻ **Mild** Painful (Can do)	◻ **Moderate** Painful (Limited)	◻ **Severe** Unable to Perform