

ABUNDANT HEALTH

CHIROPRACTIC

Confidential Patient Record

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Today's date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Mobile phone \_\_\_\_\_ Fax \_\_\_\_\_

Social Security \_\_\_\_\_ Driver's License \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Names/ Ages of Children \_\_\_\_\_ Marital Status (circle) MARRIED SINGLE DIVORCED WIDOWED

Name of Spouse \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

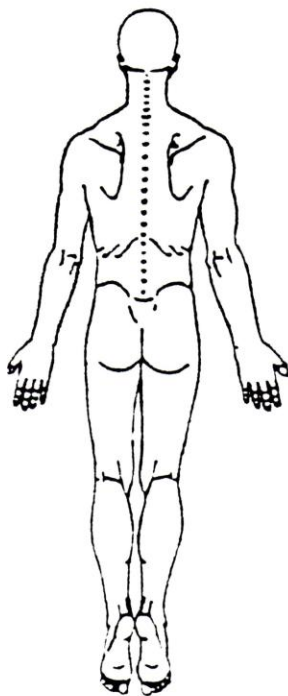
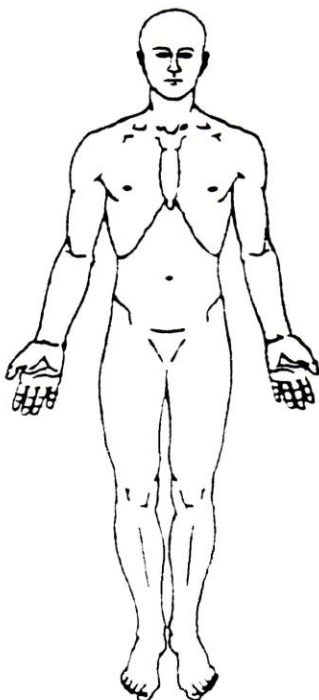
Name of Phone of Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Have you ever been to see a chiropractor before? Y N If yes, which doctor? \_\_\_\_\_

Health Evaluation

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also make any notes next to your markings if you think a description would be helpful. Then, please circle the number to the right that best represents you pain, where 1 is no pain and 10 is the worst pain you can imagine.



Rate your pain by circling the number that best describes your pain at its WORST in the past 24 hours

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes your pain at its LEAST in the past 24 hours

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the number that best describes you pain on AVERAGE for the past WEEK

1 2 3 4 5 6 7 8 9 10

**NOTE:** Please feel free to use the back page of this form if you need more room to explain any of your answers

**Complaints** – Please rate your health complaints and rate their severity (on a scale from 1-10, 10 being the worst). This could include your current pain, a chronic injury (ex. “bad” knee or shoulder), being overweight, etc.

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**Goals** – What are your goals for seeing Dr. Erica? \_\_\_\_\_

**Limitations** – What limitations do you have, if any, in working with Dr. Erica? (ex. Unwilling to take nutritional supplements, won't give up smoking or alcohol, etc).

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**Stress Level** – Rate your stress level currently on a scale from 1-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, anger, not happy with life, depression, etc.

Overall stress level: \_\_\_\_\_ Main reasons for stress \_\_\_\_\_

If over a level 5, what are you currently doing to reduce your stress? \_\_\_\_\_

**Energy Level** – List on a scale from 1-10 (1 is no energy) what your energy level is during the following times:

A.M. \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_ Late P.M. \_\_\_\_\_ After meals \_\_\_\_\_ Overall \_\_\_\_\_

**Sleep Quality** – How is your sleep? (check all that apply)  Restful  Restless  Hard to fall asleep  Wake up often

What time do you usually go to sleep? \_\_\_\_\_ Hours of sleep per night? \_\_\_\_\_

**Exercise** – Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_ For how long per session? \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

**Smoking** – Do you currently smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

**Daily Habits** – For each of these items listed below, specify how much you consume and how often (i.e. 1 cup/day).

Coffee/Tea: \_\_\_\_\_ Soda: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Water: \_\_\_\_\_ Fast food: \_\_\_\_\_

Vitamins/Minerals: \_\_\_\_\_

**Allergies** – Please list any allergies, including food allergies, drug, environmental, seasonal, etc.

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**Medical History** – Please describe any conditions which are under the care of a physician.

Diagnosis \_\_\_\_\_

Date of Onset \_\_\_\_\_ Duration of current symptoms \_\_\_\_\_

Doctor(s) involved, their specialty \_\_\_\_\_

How diagnosed (what tests)? \_\_\_\_\_

Current treatment (medication, etc.) \_\_\_\_\_

Treatment received in past, if any, and how it worked \_\_\_\_\_

**Medications** – Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Antacids        | <input type="checkbox"/> Anti-inflammatories       | <input type="checkbox"/> Diuretics  | <input type="checkbox"/> Muscle Relaxer      | <input type="checkbox"/> Steroids (prednisone, (cortisone, etc) |
| <input type="checkbox"/> Antibiotics     | <input type="checkbox"/> Birth Control Pills/Patch | <input type="checkbox"/> Hormones (estrogen, progesterone, DHEA, testosterone, thyroid) | <input type="checkbox"/> Pain Killers        |   |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Blood Pressure Medication |   | <input type="checkbox"/> Parasite Medication | <input type="checkbox"/> Fungus/Yeast Medication                |
| <input type="checkbox"/> Antihistamines  | <input type="checkbox"/> Cardiac/Heart Medication  |   |  |   |
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**Surgeries/Hospitalizations** – What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

- |                                       |  |                                     |  |   |
|---------------------------------------|--|-------------------------------------|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Breast Implants | <input type="checkbox"/> C-Sections | <input type="checkbox"/> Eye Surgery         | <input type="checkbox"/> Laparoscopy      |
| <input type="checkbox"/> Arthroscopy  | <input type="checkbox"/> Biopsies        | <input type="checkbox"/> D&Cs       | <input type="checkbox"/> Implants/Prosthesis | <input type="checkbox"/> Tonsils/Adenoids |

Other (please list all with brief details such as date, outcome, etc.) \_\_\_\_\_

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**Family History** – Has either of your grandparents, parents, or siblings suffered from any of the following:  Allergies

- Arthritis  Asthma  Cancer  Diabetes  Heart Disease  Mental Disease  Thyroid Imbalance  Other

If any of the above is checked, list the family member’s relationship to you, when their problem began, and what the outcome was: \_\_\_\_\_

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**Review of Systems** – Please check the “Now” box for all conditions that you are now experiencing and mark the “Past” box for any condition of symptoms experienced at any time in your life.

	Now	Past		Now	Past		Now	Past		Now	Past
<b>General</b>			<b>Lungs</b>			Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
<b>Head</b>			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin</b>		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	<b>G-U System</b>			Rash	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Coughing phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>	Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>
Blacking Out	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular</b>			Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Itching/peeling	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<b>Conditions</b>		
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>	TIA’s	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet/hands	<input type="checkbox"/>	<input type="checkbox"/>	Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>	Calf pain	<input type="checkbox"/>	<input type="checkbox"/>	Genital infection	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mouth</b>			Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurologic</b>			Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<b>G-I System</b>			Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson’s	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	M.S.	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nose</b>			Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<b>Muscle/Bones</b>			Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>

