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? _____

_____

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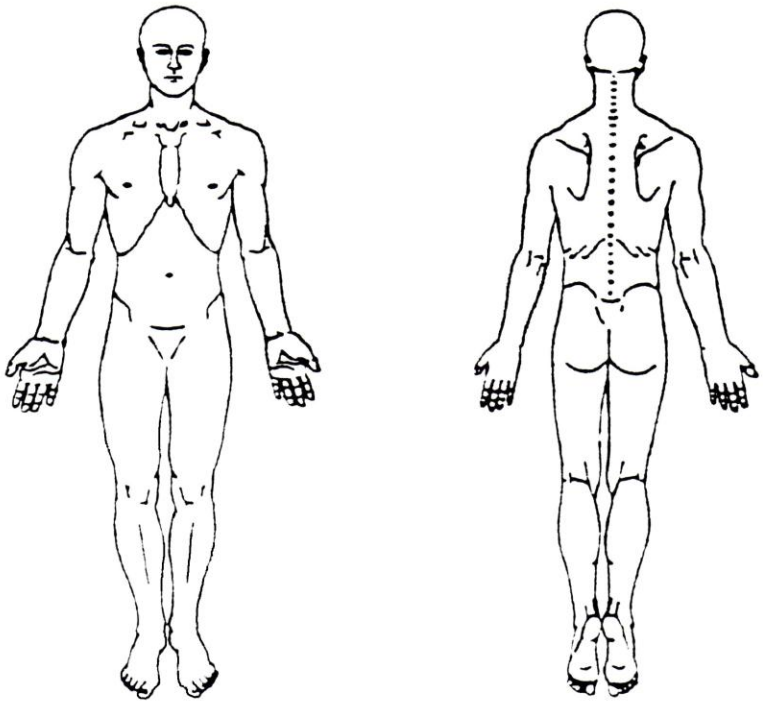
Health Evaluation

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.

_____

_____

_____

_____

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).

_____

_____

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.

_____

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.

☐ Antacids	☐ Anti-inflammatories	☐ Diuretics	☐ Muscle Relaxer	☐ Steroids (prednisone,
☐ Antibiotics	☐ Birth Control Pills/Patch	☐ Hormones (estrogen,	☐ Pain Killers	(cortisone, etc)
☐ Antidepressants	☐ Blood Pressure Medication	progesterone, DHEA,	☐ Parasite Medication	☐ Fungus/Yeast
☐ Antihistamines	☐ Cardiac/Heart Medication	testosterone, thyroid)		Medication

_____

_____

Surgeries/Hospitalizations – What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

☐ Appendectomy	☐ Breast Implants	☐ C-Sections	☐ Eye Surgery	☐ Laparoscopy
☐ Arthroscopy	☐ Biopsies	☐ D&Cs	☐ Implants/Prosthesis	☐ Tonsils/Adenoids

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

_____

_____

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:

_____

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
General		
Weight loss	☐	☐
Weight gain	☐	☐
Head		
Headache	☐	☐
Dizziness	☐	☐
Head trauma	☐	☐
Fainting	☐	☐
Blacking Out	☐	☐
Eyes		
Change in vision	☐	☐
Cataracts	☐	☐
Light sensitivity	☐	☐
Flashes in vision	☐	☐
Spots in vision	☐	☐
Mouth		
Bleeding gums	☐	☐
Cold sores	☐	☐
Dentures	☐	☐
Sore throat	☐	☐
Jaw pain	☐	☐
Changes in taste	☐	☐
Hoarseness	☐	☐
Nose		
Nosebleeds	☐	☐
Sinus problems	☐	☐

	Now	Past
Lungs		
Difficulty breathing	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Persistent cough	☐	☐
Coughing phlegm	☐	☐
Tuberculosis	☐	☐
Vascular		
Chest pain	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐
Cold feet/hands	☐	☐
Leg cramps	☐	☐
Calf pain	☐	☐
Varicose veins	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
G-I System		
Gas	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Ulcers	☐	☐
Vomiting/Nausea	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐

	Now	Past
Constipation	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Gall bladder disease	☐	☐
Liver disease	☐	☐
G-U System		
Difficulty Urinating	☐	☐
Pain urinating	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Foul odor of urine	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Urinary infection	☐	☐
Genital infection	☐	☐
Neurologic		
Seizures/Epilepsy	☐	☐
Strokes	☐	☐
Tingling sensation	☐	☐
Numbness	☐	☐
Weakness	☐	☐
Difficulty walking	☐	☐
Poor coordination	☐	☐
Muscle/Bones		
Joint pain	☐	☐
Stiffness	☐	☐

	Now	Past
Arthritis	☐	☐
Bone pain	☐	☐
Fractures	☐	☐
Dislocations	☐	☐
Skin		
Rash	☐	☐
Bruising	☐	☐
Changes in moles	☐	☐
Itching/peeling	☐	☐
Conditions		
TIA's	☐	☐
Hypertension	☐	☐
Diabetes	☐	☐
Thyroid condition	☐	☐
Heart condition	☐	☐
Rheumatism	☐	☐
Glaucoma	☐	☐
Cancer/Tumor	☐	☐
Polio	☐	☐
Parkinson's	☐	☐
M.S.	☐	☐
Gout	☐	☐
Anemia	☐	☐
Osteoporosis	☐	☐
High cholesterol	☐	☐
Migraines	☐	☐