

Confidential Patient Health Record

Today's Date: ____ / ____ / ____

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

Title: Mr. Ms. Mrs.

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:** _____

Children (Names and Ages): _____

Emergency Contact

Last: _____ **First:** _____ **Middle:** _____

Relationship: Spouse Relative Friend Other _____

Home Phone: (____) _____ - _____ **ext** _____ **Cell Phone:** (____) _____ - _____ **ext** _____

Work Phone: (____) _____ - _____ **ext** _____

Employment Information

Business Name: _____

Phone: (____) _____ - _____ **Fax #:** (____) _____ - _____

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

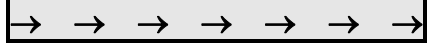
Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Patient Name: _____

Date: _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



**Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing**

When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

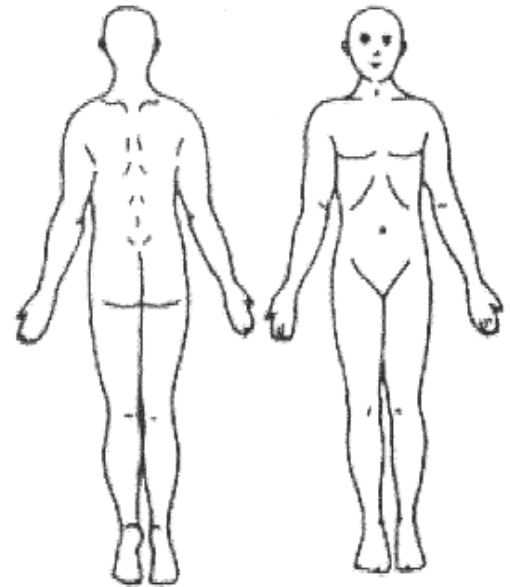
Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



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 fatigue night sweats weight loss
- daytime drowsiness fever weight gain

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

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

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

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

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

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

Patient Name: _____

Date: _____

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

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

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

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

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

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

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

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

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

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

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

Patient Name: _____

Date: _____

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

Previous Care for this Same Condition:

I have not previously 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
- atopic dermatitis (eczema)
- allergies/hayfever
- anemia
- asthma
- bedwetting
- cerebral palsy
- chicken pox
- crohn's/colitis
- depression
- diabetes
- ear infections
- fetal drug exposure
- food allergies (list below)
- headaches
- hepatitis
- HIV
- measles
- mumps
- psoriasis
- rash
- scoliosis
- seizure disorder
- sickle cell anemia
- spina bifida
- other:

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

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

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

Patient Name: _____

Date: _____

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: |

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

- | | | | | | |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Insurance Information:

Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es)) Myself **ONLY**

Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: ____-____-____ Primary Care Physician: _____

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 #: _____

Patient Name: _____

Date: _____

I understand that by signing below I am giving my permission for Yucha Chiropractic Health Center to release reports of my initial and continuing care to my primary care physician. I understand that I can suspend this permission at any time.

_____ Primary Care Physician's Name

_____ Patient Signature

_____ Date

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____