

CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL HISTORY

*Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Social Security #: _____
 Driver's License #: _____
 Business Employer: _____
 Occupation: _____
 Name of Spouse: _____
 Type of Work: _____
 *Referred By: _____
 Emergency Contact: _____
 Who is Responsible for your bill: You *and/or* Spouse
 Health Insurance Carrier: _____
 Insured Person's Name: _____
 Insured's Date of Birth: _____
 Insured's Social Security #: _____

*Birth Date: _____ *Age: _____
 *Sex: Male/Female
 *Home Phone: _____
 Cell Phone: _____
 E-Mail Address: _____
 Fax #: _____
 Business Phone #: _____
 Spouse's Employer: _____
 Names & Ages of Children: _____

 Relationship: _____
 Auto Insurance Medicare Insurance
 Health Card ID#: _____
 Group #: _____
 Have You Had Previous Chiropractic Care? _____
 Name of Previous Chiropractor: _____
 Amount of Time Under Care of a Chiropractor? _____

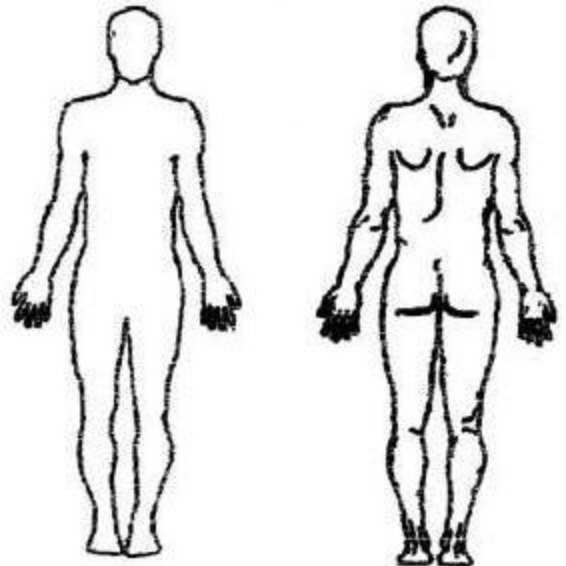
*Exam For? Self Family

OFFICE PORTION:				
Patient ID#: _____		Visit Date/Time: _____		
Case Type:	Cash	Insurance	Medicare	Personal Injury

CURRENT HEALTH CONDITION

*Chief Complaint (why you're here today)

PLEASE OUTLINE ON DIAGRAM THE AREA OF DISCOMFORT*



When did this condition begin? _____
 Has it occurred before? Yes No
 Is condition: Auto Related Work Related Other No Injury
 Explain: _____

Date of Accident: _____
 Time of Accident: _____

Complaint/Pain Onset Date: _____

Patient Name: _____

Date: _____

CHIEF COMPLAINT – HPI FORM

MECHANISM OF ONSET:

1.) Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (example: fall, auto injury, sports trauma, repetitive motion of the job.)

SYMPTOMS: When this problem is at it's worst, can you explain in your words how exactly it feels? Does it radiate?

QUALITY:

Burning Diffuse Dull/Aching Localized Sharp
 Shooting Stabbing Tingling Radiating Other _____

TIMING:

Worse AM Worse during afternoon Worse w/ Activity Intermittent Constant Worse PM
How often do you find yourself suffering from this problem? _____
How long does the problem last? (Get all the details of timing) _____

DAILY ACTIVITIES: Effects of Current Condition on Performance

Care – Family Member				
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Change Positions –				
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Self Care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Self Care – Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to perform

MEDICATIONS: What medications are you currently taking, and for what conditions?

Patient Name: _____

Date: _____

RECREATIONAL ACTIVITY:

- | | | | | |
|-------|------------------------------------|---|---|--|
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to perform |

YOUR LIFE REVIEW – LIFESTYLE CHIROPRACTIC EXPERIENCE

Please Check All That Apply (even if not seemingly related to your concern to note how nerve interference is impacting you HEALTH)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Fainting | <input type="checkbox"/> Numbness in Fingers/Toes |
| <input type="checkbox"/> Buzzing/Ringing in Ears | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Loss of Smell/Taste |
| <input type="checkbox"/> Cold Feet/Hands | <input type="checkbox"/> Mood Swings/Irritability | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Tension | <input type="checkbox"/> Upset Stomach/Heartburn |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Loss of Balance/Dizziness | |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins & Needles in Legs/Arms | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Constipation | | |

Do these conditions disrupt: (Circle all that apply)	Social Life Sleep Patterns	Family Career	Ability to Exercise Other
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What methods have you tested to relieve your pain? (Circle all that apply.)

- | | | | |
|----------|------------------|---------|--------------|
| Exercise | Physical Therapy | Massage | Diet Changes |
| Drugs | Supplements | Surgery | Other _____ |

Were any of these methods successful at addressing the problem? Y / N

If "No", circle the following if applicable:

- | | |
|----------------------------|------------------------------|
| The problem worsened | I want to be energetic again |
| I want answers and results | I want to be healthy |

On a scale of 1 to 10, ten being the highest, rate the importance of finding the cause of your problem:

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of the problem?

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, ten being the highest, rate the importance of quality of life?

1 2 3 4 5 6 7 8 9 10

What results do you want? (Circle all that apply.)

- | | | |
|--------------|-----------------|-------------------|
| Reduced Pain | Restored Health | Maintained Health |
|--------------|-----------------|-------------------|

What excuses have stopped you from being well?

- | | | |
|------|-------|-------------|
| Time | Money | Other _____ |
|------|-------|-------------|

FAMILY HISTORY
(Please check all that apply.)

- | | | | | |
|---|---------------------------------------|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> High Stress | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vaccine Reaction | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ | | | |

TERMS OF ACCEPTANCE/ CHIROPRACTIC INFORMED CONSENT AGREEMENT

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and, if necessary, diagnostic x-rays on me by the doctor or chiropractic named above and/or anyone authorized by the same doctor. I further understand and am informed that River City Chiropractic does not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, the doctor encounters non-chiropractic or unusual findings, he/she will inform me and offer referral. Regardless of what the disease is called, the doctor will not offer to treat it, nor will he/she offer advice regarding treatment prescribed by others.

River City Chiropractic's only objective is to eliminate interference to the expression of the body's innate wisdom. As in all health care, there are some slight risks to treatment. I do not expect the doctor to be able to anticipate or explain all risks and combinations. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation.

I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

SIGNATURE: _____

PRINT: _____

WITNESS: _____

DATE: _____