Confidential	Patient	Health	Record
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DATE	I.D. NO.	

## PERSONAL HISTORY

Name:	Address:						
City:							
Home Phone:		•					
Cell Phone:							
Social Security #	Driver's License Number:						
Social Insurance #							
Business Employer:							
Business Phone:	Spouse's Social Security #						
Name of Spouse	Spouse's Social Insurance	#					
Spouse's Employer	,						
Type of Work							
Referred To This Office By:							
Name and Number of Emergency Contact:							
Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Wo							
Personal Health Insurance (Name)		d #					
Insured Person's Name	Date of Birth						
	ALTH CONDITION						
Unwanted Health Condition							
Other Doctors Seen For This Condition:   Yes   No							
Type of Treatment:							
When Did This Condition Begin?		d Before?   Ye	s □ No				
Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home In							
Date of Accident:							
Have You Made A Report of Your Accident To Your Employer							
Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle		Medicine					
□ Insulin □ Other							
Do You Wear A Shoe Lift? ☐ Yes ☐ No							
Do You Suffer From Any Condition Other Than That Which Y	ou Are Now Consulting Us?_						
PAST HEA	LTH HISTORY						
Please Check and Describe:							
Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillect	omy □ Gall Bladder □ Her	nia 🗆 Back Sur	gery				
☐ Broken Bones ☐ Other							
Major Accident or Falls:							
Hospitalization (Other Than Above):							
Previous Chiropractic Care: ☐ None ☐ Doctor's Name & A	Approximate Date of Last Visit	<u> </u>	·				

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD: Pneumonia   Mumps	Below are a list of disease must be answered carefully	s which may seem y as these problem	unrelated to the purpose of your can affect your overall cours	our appointment. However, the of care.	ese questions
Rheumatic Fever   Small Pox   Plaurisy   Coffee   Polio Chicken Pox   Chicken Pox   Arthritis   Data   Alcohol   Chicken Pox   Arthritis   Data   Alcohol   Alcoholol   Alcohololol   Alcoholololololololololololololololololol	CHECK ANY OF THE FOI	LLOWING DISEAS	SES YOU HAVE HAD:		
Rheumatic Fever   Small Pox   Plaurisy   Coffee   Polio Chicken Pox   Chicken Pox   Arthritis   Data   Alcohol   Chicken Pox   Arthritis   Data   Alcohol   Alcoholol   Alcohololol   Alcoholololololololololololololololololol				INTAKE	
Pollo					
Tuberculosis   Diabetes   Epileosy   Alcohol   Montal Disorders   Gigarettes   Montal Disorders   White Sugar   Montal Disorders   Montal Disorders   White Sugar   Montal Disorders   Montal Dis					
Minoping Cough					
Measles   Heart Disease   Lumbago   White Sugar					
Measles					
Have you been tested HIV positive?			e 🗆 Lumbago	☐ White Sugar	
CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:  MUSCULO-SKELETAL CODE    Low Back Pain   Gas/Bloating After Meals   When was your last period?     Pain Between Shoulders   Gas/Bloating After Meals   When was your last period?     Arm Pain   Gallboard Stool   Are you pregnant?     Arm Pain   Gallboard Stool   Gallboard Stool   Are you pregnant?     Are you pregnant?   Are you pregnant?   Are you pregnant?     Are you pregnant?   Are you pregnant?   Are you pregnant?     Are you pregnant?   Are you pregnant   Are you pregnant   Are you pregnant     Are you pregnant?   Are you pregnant   Are you pregnant   Are you pregnant     Are you pregnant?   Are you pregnant   Are you pregnant     Are you pregnant?   Are you pregnant   Are you pregnant     Are you pregnant?   Are you pregnant     Are you pregnant   Are you pregnant   Are you pregnant     Are you pregnant   Are you pregnant   Are you pregnant     Are you pregnant   Are you pregnant     Are you pregnant   Are you pregna	.□ Measles	☐ Thyroid	Eczema		
MUSCULO-SKELETAL CODE	Have you been tested HIV	positive? ☐ Yes	□ No		
Dev Back Pain			VE HAD THE PAST 6 MONTH	HS:	
Pari Between Shoulders				FEMALES ONLY:	
Neck Pain			as/Bloating After Meals	When was your last peri	od?
Joint Pain/Siffness   Valking Problems   Valking Problems   Paint/Siffness   Valking Problems   Valking Problems   Paint/Excessive Urination   Discolored Urine   Paint/Excessive Urination   Painting   Paint/Excessive Urination   Painting   Paint/Excessive Verins   Painting   Pa	□ Pain Between Shoulders	B □ H	leartburn		
Joint Pain/Stiffness   Valking Problems   Gentro-Urinary Code   Bladder Trouble   Bladder Problems   Bladder Problems   Bladder Problems   Bladder Bladder   Bladder Bladder Bladder   Bladder Bladder Bladder   Bladder Bladder Bladder   Bladder Bladder Bladder Bladder   Bladder Bla	□ Neck Pain	□ B	lack/Bloody Stool	Are you pregnant?	
Joint Pain/Stiffness   Genitro-Urinnary Code   Bladder Trouble   Bladder	□ Arm Pain				ot Sure
General Stiffness   Painfulk*Excessive Urination   Discolored Urine   Painfulk*Excessive Urination   Painfulk*Excessive Urination   Discolored Urine   Discolor	☐ Joint Pain/Stiffness				
General Stiffness   Painfulk*Excessive Urination   Discolored Urine   Painfulk*Excessive Urination   Painfulk*Excessive Urination   Discolored Urine   Discolor	☐ Walking Problems	GEN	IITO-URINARY CODE		
General Stiffness					$\supset$
Discolored Urine				( ) (	<del>(2)</del>
NERVOUS SYSTEM CODE	□ dellerar offinitess				
Nervous   Chest Pain   Cobe   Chest Pain   Numbness   Short Breath   Short S			iscolored Offine		$\lambda$
Nervous	NEDVOUS SYSTEM SOD	- 01	D 00DE	1)	::11
Numbness   Short Breath   Blood Pressure Problems   Dizziness   Irregular Heartbeat   Heart Problems   Gonfusion/Depression   Lung Problems/Congestion   Fainting   Varicose Veins   Convulsions   Ankle Swelling   Stroke   Strok				11 ~ 11	<b>ヘル</b> /
Paralysis   Blood Pressure Problems   Irregular Heartbeat   Problems   Progretiuness   Heart Problems   Prob				(1) 5 (() (1)	• 1/1
Dizziness   Irregular Heartbeat   Heart Problems   Confusion/Depression   Lung Problems/Congestion   Fainting   Varicose Veins   Varicose Veins   Varicose Veins   Varicose Veins   Convulsions   Ankle Swelling   Convulsions   Ankle Swelling   Convulsions   Ankle Swelling   Convulsions   Ankle Swelling   Convulsions   Conv				- /// / /// ///	$\mathcal{N}\mathcal{N}$
Forgetfulness   Lung Problems   Lung Problems   Confusion/Depression   Lung Problems/Congestion   Fainting   Varicose Veins   Ankle Swelling   Convulsions   Stroke   Convulsions   Ankle Swelling   Convulsions   C		□ B	lood Pressure Problems	(1)	1 13
Confusion/Depression					11
Fainting		□ H	eart Problems	\ 1 / \	<b>A</b> (
Convulsions   Stroke   Strok	□ Confusion/Depression		ung Problems/Congestion	}- <b>1</b> - ( )	11-1
Cold/Tingling Extremities   Stroke   Stress	□ Fainting	□V	aricose Veins	(1)	11 /
Cold/Tingling Extremities   Stroke   Stress	□ Convulsions	□ A	nkle Swelling	/ // /	(1)/
GENERAL CODE   Fatigue	☐ Cold/Tinalina Extremities	s $\Box$ S		H-(	/ \
Fatigue				UD '	لعالب
Fatigue	05115011 0055				
Allergies					
Loss of Sleep					igram the
Fever		□ D	ental Problems	area of your discomfort	
Headaches	☐ Loss of Sleep	□s	ore Throat		
GASTRO-INTESTINAL CODE   MALE/FEMALE CODE   FAMILY HISTORY	☐ Fever	□ <b>E</b>	ar Aches		
GASTRO-INTESTINAL CODE   MALE/FEMALE CODE   FAMILY HISTORY	☐ Headaches	□ H	earing Difficulty		
Poor/Excessive Appetite					
Poor/Excessive Appetite	,				
Excessive Thirst					
Excessive Thirst	□ Poor/Excessive Appetite	□ M	lenstrual Irregularity	The following members I	nave a
Frequent Nausea   Vaginal Pain/Infection   Mother   Vomiting   Breast Pain/Lumps   Father   Diarrhea   Prostate/Sexual Dysfunction   Brother   Constipation   Other Problems   Sister   Hemorrhoids   Spouse   Liver Problems   Child   Spouse   Liver Problems   Child   Gall Bladder Problems   Child   Gall Bladder Problems   Inderstand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.  I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.  Patient's Signature Date  Consent to Treat a Minor Date	☐ Excessive Thirst	. 🗆 M	lenstrual Cramps		
Vomiting	□ Frequent Nausea	□ V:	aginal Pain/Infection	•	
Diarrhea   Prostate/Sexual Dysfunction   Brother   Constipation   Other Problems   Sister   Spouse   Liver Problems   Spouse   Liver Problems   Child   Gall Bladder Problems   Child   Child					
Constipation   Other Problems   Sister   Spouse   Liver Problems   Spouse   Liver Problems   Child   Gall Bladder Problems   Child					
Hemorrhoids   Spouse   Child   Spouse   Child   Gall Bladder Problems   Child   Chil					
Liver Problems					
Gall Bladder Problems  Weight Trouble Abdominal Cramps    understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.  I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.    Date					
□ Weight Trouble □ Abdominal Cramps  I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.  I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.  Patient's Signature		H -			
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Consent to Treat a Minor Date  Guardian or Spouse's	services rendered me are charged di fees for professional services rendered I hereby authorize the Doctor to treat is for examination only and the X-ray	rectly to me and that I to ed me will be immediate i my condition as he or negatives will remain to	am personally responsible for paymer aly due and payable. she deems appropriate. It is understo he property of this office, being on file	nt. I also understand that it I suspen and and agreed the amount paid the	or terminate, any  Doctor, for x-rays,
Consent to Treat a Minor Date	Patient's Signature			Date	
Guardian or Spouse's				Date	
				Date	