FAMILY CHIROPRACTIC ASSOCIATES

Patient Health Record

Legal Name (First & Last): _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Gender: _____

Occupation: _____ Employer: _____

Social Security #: _____ Primary Care Physician: _____

Marital Status: _____ Significant Other Name: _____

Do you have any children? (include ages)_____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Reason for your visit

Describe the purpose of this visit: _____

_____

When did this condition begin? _____

What makes it better? _____

What makes it worse? _____

Does the pain: ☐ Stay in one spot ☐ Radiate to other areas (location)_____

Type of pain: ☐ Sharp with motion ☐ Deep burning ☐ Dull ache ☐ Throbbing

How often do you experience your symptoms?

☐ Intermittent (less than 25% when awake) ☐ Occasional (25-50% when awake)

☐ Frequent (50-75% when awake) ☐ Constant (75-100% when awake)

Has this condition:

☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:

☐ Work ☐ Sleep ☐ Daily routine ☐ Exercise ☐ Home life ☐ Driving

☐ Standing ☐ Sitting ☐ Bending ☐ Other: _____

Has this condition occurred before? ☐ No ☐ Yes (explain) _____

Have you seen other doctors for this condition?

☐ No ☐ Yes (Name, type of treatment & results): _____

_____

Any recent traumas, surgeries or hospitalizations? _____

Any other recent health concerns? _____

Current medications: ☐ None ☐ Muscle relaxant ☐ Cholesterol medication (statins)

☐ Insulin ☐ Antidepressants ☐ Blood pressure medication

☐ NSAID ☐ Blood thinner ☐ Pain medication (incl. aspirin)

☐ _____ ☐ _____

Your experience with Chiropractic

Who referred you to this office? _____

Have you been adjusted by a chiropractor before? ☐ No ☐ Yes (Doctor's Name): _____

If yes, reason for those visits: _____ Approx. date of last visit: _____

Has any adult in your family seen a chiropractor? ☐ No ☐ Yes

Has any child in your family seen a chiropractor? ☐ No ☐ Yes

Your Health Conditions

Please check each of the conditions or diseases that you are experiencing now or have had in the past. While these may seem unrelated to the purpose of the appointment, they can affect the overall analysis, care plan and the possibility of being a candidate for care.

- ☐ Severe or frequent headaches
- ☐ Frequent neck pain
- ☐ Numbness in arms/hands
- ☐ Pain in arms/hands
- ☐ Numbness in legs/feet
- ☐ Pain in legs/feet
- ☐ Pain between shoulders
- ☐ Lower back problems
- ☐ Arthritis
- ☐ Thyroid problems
- ☐ Shingles
- ☐ Surgeries
- ☐ Sinus problems
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Alcohol/drug abuse
- ☐ HIV/AIDS
- ☐ Psychiatric problems
- ☐ Digestive problems
- ☐ Ulcers/Colitis
- ☐ Pelvic pain
- ☐ _____
- ☐ Dizziness
- ☐ Loss of sleep
- ☐ Heart murmur
- ☐ High/low blood pressure
- ☐ Congenital heart defect
- ☐ Heart attack/stroke
- ☐ Heart surgery/pacemaker
- ☐ Hepatitis
- ☐ Kidney problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ _____

For women:

Do you experience painful periods?	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No			

Your Current Lifestyle

Physical

Do you exercise regularly?	☐ Yes	☐ No
Are you stretching daily?	☐ Yes	☐ No
Are you interested in exercise?	☐ Yes	☐ No
Do you pay attention to posture?	☐ Yes	☐ No

Bio-Chemical

Do you eat prepared, processed or fast foods?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Do you consume caffeinated, carbonated, or drinks high in sugar daily?	☐ Yes	☐ No
Do you take nutritional supplements?	☐ Yes	☐ No

Mental/Emotional

Do you feel "stressed out" regularly?	☐ Yes	☐ No
Do you practice relaxation/meditation techniques daily?	☐ Yes	☐ No
Do you handle stress in a positive way?	☐ Yes	☐ No
Is lack of time and/or energy during the day a source of stress for you?	☐ Yes	☐ No

Goals for Your Health

Would you like help with:

Improving posture	☐ Yes	☐ No
Exercise	☐ Yes	☐ No
Nutrition	☐ Yes	☐ No
Meditation	☐ Yes	☐ No
Stress reduction	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Flexibility	☐ Yes	☐ No
Reducing current medications	☐ Yes	☐ No

Additional health goals or comments:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____