CONFIDENTIAL PATIENT HEALTH RECORD

Date ____________________

PERSONAL HISTORY

Name: ____

Address: ____

City ________________________ State: _____ Zip: _________

Social Security #: _______________________________________

Driver's License #: ______________________________________

Business Employer: ______________________________________

Occupation: ____

Name of Spouse: ____

Type of Work: ____

Referred To This Office By: _______________________________

Name & Number of Emergency Contact: ____________________

Birth Date _________________________ Age: ____________________

Sex: Male / Female

Home Phone: ____

Cell Phone: ____

E-mail Address: ____

Fax #: ____

Business Phone: ____

Spouse's Employer: ____

Names & Ages of children: _____________________________________

____

Relationship: ____

Who is Responsible for your bill, you and ☐ Spouse ☐ Worker's Comp ☐ Auto insurance ☐ Medicare ☐ Medicaid

Personal Health Insurance Carrier: _________________________

Insured Person's Name: __________________________________

Insured Person's Date of Birth: ____________________________

Insured Person's Social Security #: _________________________

Health Card ID #: ____

Group #: ____

Primary Care Physician: _______________________________________

Pharmacy: ____

CURRENT HEALTH CONDITION

Chief complaint (why you're here today) ____________________

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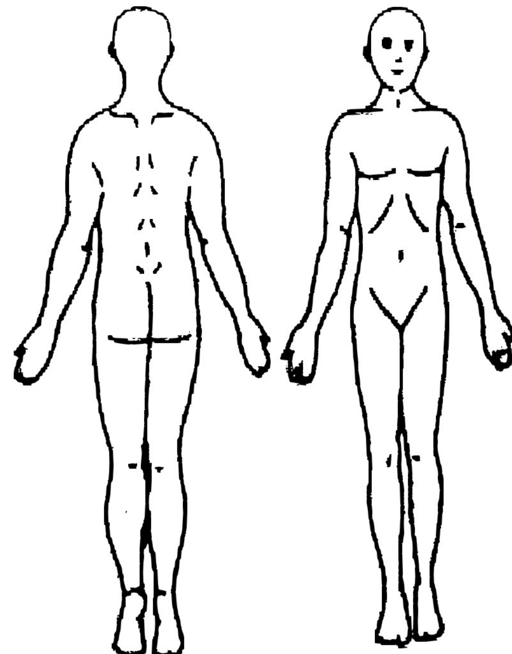
PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? ___________________________

Has it ever occurred before? ☐ Yes ☐ No

Is condition: ☐ Auto Related ☐ Work Related ☐ Other ☐ No Injury

Explain: ____

Date of Accident: _____________________________________

Time of Accident: _____________________________________

Complaint / Pain Onset Date: ___________________________

If Work: Have you filed an Injury report with your employer?

☐ Yes ☐ No

Claim #: ____

GENERAL SYMPTOMS Check (x) symptoms your currently have or had in the past year

GENERAL

- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_________________

NECK, BACK, EXTRIMITIES Check (x) symptoms you currently have or have had in the past year.

NECK

- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS

	Right	Left
☐ Pain in shoulder joint	☐ R	☐ L
☐ Pain across shoulders		
☐ Can't raise arm	☐ R	☐ L
☐ Above shoulder level		
☐ Over head		
☐ Tension in shoulders		
☐ Pinched nerve in shoulder	☐ R	☐ L

MID-BACK

- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades

ARMS & HANDS

☐ Pain in upper arm	☐ R	☐ L
☐ Pain in elbow	☐ R	☐ L
☐ Pain in forearm	☐ R	☐ L
☐ Pain in hand	☐ R	☐ L
☐ Pain in fingers	☐ R	☐ L
☐ Pins & needles in arm	☐ R	☐ L
☐ Pins & needles in fingers	☐ R	☐ L
☐ Numbness in arm	☐ R	☐ L
☐ Numbness in fingers	☐ R	☐ L
☐ Weakness of arm	☐ R	☐ L
☐ Weakness of hand	☐ R	☐ L
☐ Hands cold	☐ R	☐ L

LOW BACK

- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low-back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low-back

HIP LEGS & FEET

☐ Pain in buttocks	☐ R	☐ L
☐ Pain in hip joint	☐ R	☐ L
☐ Pain down leg	☐ R	☐ L
☐ Pain in knee	☐ R	☐ L
☐ Pain in ankle	☐ R	☐ L
☐ Pain in foot	☐ R	☐ L
☐ Weakness of leg	☐ R	☐ L

OTHER SYMPTOMS

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ Patient Signature

___________________________ Date

____ Doctor

___________________________ Date