PATIENT # ________ Date ___/___/___

CONFIDENTIAL CLINICAL RECORD

GENERAL INFORMATION - PLEASE PRINT

PATIENT NAME ________ HOME ADDRESS ________

CITY ________ STATE ____ ZIP CODE ____ HOW LONG? ____

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT ADDRESS ________ CITY ________ STATE ____ ZIP CODE ____

BIRTHDATE ___/___/___ SEX: M — F ___ MARITAL STATUS M __ S __ D __ W __ CHILDREN ________

YOUR EMPLOYER ________ CITY ________ YEARS WITH FIRM ____

OCCUPATION ________ SOCIAL SECURITY # ___/___/___

DRIVERS LICENSE NO. ________ HOME PHONE ________ WORK PHONE ________

CELL PHONE ________ EMAIL ________

SPOUSE'S NAME ________ S.S. # ___/___/___ OCCUPATION ________

SPOUSE'S EMPLOYER ________ CITY ________ HOW LONG? ____

NEAREST RELATIVE NOT LIVING WITH YOU ________

ADDRESS ________ CITY ________ PHONE ________

PHYSICIAN ________ DATE OF LAST PHYSICAL ________

DENTIST ________ DATE OF LAST VISIT ________

DATE OF LAST CHIROPRACTIC ADJUSTMENT ___/___/___ SEEN BY DR. ________

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? ________

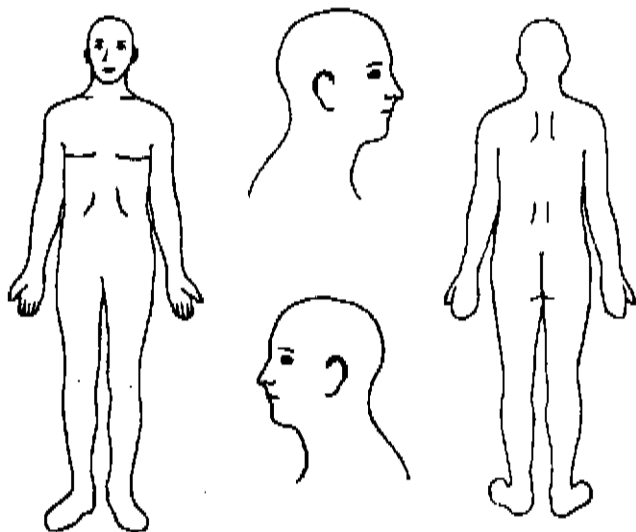
ADDRESS IF DIFFERENT ________ PHONE ________

WHO MAY WE CONTACT IN CASE OF EMERGENCY? ________

PHONE ________ WHOM MAY WE THANK FOR REFERRING YOU TO US? ________

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT

(Describe in your own words your problem and how it happened or started)

____

____

____

____

____

____

When was the very first time you were aware of this problem?

____

Have you ever had this problem or similar problem before? ____

If yes, explain: ________

____

____

Have you ever received any treatment for this condition? ____
If yes, when, where and what were the results?

____

____

____

____

Is the problem better ☐ worse ☐ the same ☐

What makes it better? ________

What makes it worse? ________

____

102 — 5/91

PLEASE COMPLETE REVERSE SIDE

How has this problem affected your life:

A. Home ____

B. Work ____

C. Recreation ____

D. Rest and Sleep ____

List all surgery you have had and the dates

____

____

____

____

Have you ever been in an automobile accident? ☐ Never ☐ Past Yr. ☐ Past 5 Years ☐ Over 5 Yrs.

Describe any other accidents or falls you have ever had ____

____

Have you ever? Been stunned or unconscious ☐ Had broken bones ☐ Used a cane or crutch ☐ Been hospitalized ☐ What for ____

Had a nervous breakdown ☐

Had any major illness ☐ Describe ____

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other (please list) ____

Have you or any of your blood relatives had? ☐ High Blood Pressure ☐ Venereal Disease ☐ Tuberculosis ☐ Heart Disease ☐ Diabetes ☐ Arthritis ☐ Epilepsy ☐ Cancer ☐ Polio

Habits: fill in number or check those that apply

No. hours sleep ____ Exercise routinely ☐ Do you smoke ☐

How many cups or glasses ____ ☐ tea ____ ☐ coffee ____ ☐ soda ____ ☐ alcohol

Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

GENERAL SYMPTOMS

784.0 Headache
346.9 Migraine headache
780.8 Night Sweating
780.2 Fainting
780.4 Dizziness
780.3 Convulsions
780.52 Loss of sleep
780.7 Fatigue
799.2 Nervousness
783 Loss of weight
278.0 Obesity
995.3 Allergy
781 Tremors

E.E.N.T.

368.9 Failing vision
389.9 Deafness
388.70 Earache
388.30 Ear noises
784.7 Nose bleeds
462 Sore throat
493.9 Asthma
460 Frequent colds
240.9 Enlarged thyroid
686.9 Sinus problems

SKIN

698.9 Itching
287.8 Bruises easily
701.1 Dryness
454.9 Varicose veins
782 Sensitive skin

RESPIRATORY

786.2 Chronic cough
786.50 Chest pain
786.09 Pain or difficulty breathing with exercise

CARDIO-VASCULAR

785 Rapid beating heart
427.89 Slow beating heart
401.9 High blood pressure
458.9 Low blood pressure
786.51 Pain over heart
719 07 Swelling of ankles Right ☐ Left ☐
436 Paralytic stroke

MUSCLE & JOINT SYMPTOMS

716.9 Arthritis
782 Numbness/pain in arms hands, or legs, toes
719 Swollen joints
719.7 Difficulty in walking
722.10 Low back pain
722.2 Disc displacement
723.1 Pain in neck
723.5 Stiff neck
724.1 Pain between shoulders
724.79 Painful tailbone
728.85 Muscle spasms
729.4 Foot trouble
737 Faulty posture
737.3 Spinal curvature
781 Tremors
____ Shoulder pain
____ Knee pain
____ Elbow pain
____ Ankle pain

GENITOURINARY SYMPTOMS

788.3 Frequent urination
788.1 Painful urination
592 Kidney infection/stones
601.9 Prostate trouble

GASTROINTESTINAL SYMPTOMS

783 Poor appetite
994.2 Excessive hunger
787.3 Belching or gas
787 Nausea or Vomiting
536.8 Pain over stomach
564 Constipation
558.9 Diarrhea
789 Colon trouble
455.6 Hemorrhoids (Piles)
575.9 Gall bladder trouble
558.9 Colitis

FOR WOMEN ONLY

611.72 Lumps in breast
623.5 Vaginal discharge
625.3 Painful menstrual periods
626.2 Excessive flow
626.4 Irregular cycle
627.2 Menopausal symptoms

Date of last period ____ / ____ / ____
Are you pregnant? ____
Number of pregnancies ____
Number of live births ____
Birth Control method ____

Signature ____
Patient/Guardian