

**Confidential Patient Health Record**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: S M W D How many children? \_\_\_\_\_

Social Security No. \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Name of Wife/Husband \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_

Other Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Previous Chiropractic care? Yes \_\_\_\_\_ No \_\_\_\_\_ Reason for consulting this office

By whom \_\_\_\_\_ Eliminating symptoms or disease \_\_\_\_\_

For what \_\_\_\_\_ Preventing symptoms of disease \_\_\_\_\_

When \_\_\_\_\_ Xrays taken? \_\_\_\_\_ Maximizing health potential \_\_\_\_\_

Is your condition due to an accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes: Auto \_\_\_\_\_ Home \_\_\_\_\_ Leisure \_\_\_\_\_ Sports \_\_\_\_\_ Other \_\_\_\_\_

Chief complaints: (What is bothering you?)

1. \_\_\_\_\_

How long? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

What does it feel like? \_\_\_\_\_

Does the pain radiate? \_\_\_\_\_

How often does it bother you? \_\_\_\_\_

Describe any treatment previously received for this complaint \_\_\_\_\_

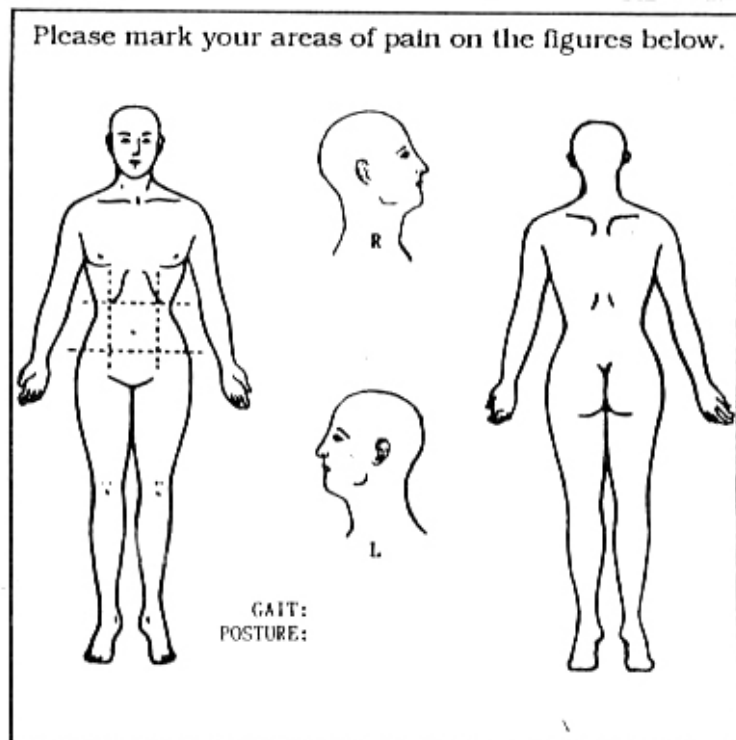
\_\_\_\_\_

Chief complaints: (What is bothering you?)

2. \_\_\_\_\_
- How long? \_\_\_\_\_
- What makes it feel better? \_\_\_\_\_
- What makes it feel worse? \_\_\_\_\_
- What does it feel like? \_\_\_\_\_
- Does the pain radiate? \_\_\_\_\_
- How often does it bother you? \_\_\_\_\_
- Describe any treatment previously received for this complaint \_\_\_\_\_
- \_\_\_\_\_

Chief complaints: (What is bothering you?)

3. \_\_\_\_\_
- How long? \_\_\_\_\_
- What makes it feel better? \_\_\_\_\_
- What makes it feel worse? \_\_\_\_\_
- What does it feel like? \_\_\_\_\_
- Does the pain radiate? \_\_\_\_\_
- How often does it bother you? \_\_\_\_\_
- Describe any treatment previously received for this complaint \_\_\_\_\_
- \_\_\_\_\_



**Circle current conditions...Check former conditions:**

**HEAD AND NECK AREA:**

Headaches	Stiff neck	Neck pain	
Poor posture	Light sensitivity	Tension	Sinus disorder
Restricted neck movement	Zig Zag flashes	High blood pressure	Head colds
Nervousness	Nausea	Tremors	Sore throat
Personality change	Eye or sinus pain	Insomnia	Hoarseness
Hayfever/allergies	Facial spasms	Dizziness	HIV – positive (AIDS)
Skin disorder	Anxiety	Vertigo	
Visual disturbances	Irritability	Earache R L	

**UPPER BACK AREA**

Shoulder pain – front – back	Asthma	Numbness/tingling arms/hands R L	Chronic cough
Upper back pain	Sore aching muscles across shoulders	Pain around collar bone	Spitting up phlegm/blood
Arm pain R L	Chest Colds	Joint stiffness/pain – arms/hands R L	Difficult breathing
Swollen joints-arms/hand R L	Thyroid condition	Rapid beating heart	Elbow pain
Arthritis	Respiratory disorder	Slow beating heart	Wrist pain
Restricted movement - shoulder/arm R L	Hot/cold spots arms/hands R L		Hand pain

**MID BACK AREA**

Middle back pain	Abdominal pain	Liver disorder	Tiredness
Scoliosis	Gall Bladder problems	Fevers	Hiatal hernia
Chest pain	Jaundice	Low blood pressure	Heart attack
Pain beneath/below breast bone	Shingles	Stomach disorder	Kidney disorder
Restricted movement-mid-back	Gas/heartburn/gastritis	Food allergies	
Rib cage pain	Psoriasis		

**LOW BACK AND PELVIS**

Low back pain	Upper leg pain R L	Numbness/tingling-legs/feet R L	Prostatitis
Painful tailbone	Lower leg pain R L	Leg cramps R L	Colitis
Hip pain	Foot pain R L	Diarrhea	Diverticulitis -
Sciatica	Hernia	Constipation	Impotence
Knee pain R L	Buttock pain	Hemorrhoids	Cramping
Swollen joints-leg/foot R L	Varicose veins	Changes in urination	Irregular/painful period
Restricted movement-leg/foot R L	Cold feet	Poor circulation	
	Hot/cold spots-legs/feet R L		

Other health symptoms: \_\_\_\_\_

Describe any family health problems (parents, spouse, children): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any surgeries you have had and the dates.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

List any medication you are taking. (Include over-the counter and vitamins)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

List any accidents in which you received injuries and dates (car, slips and falls, work, etc.)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

List serious illnesses you have had and dates diagnosed, (cancer, heart attack, stroke, infections, etc.)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

List leisure activities:

- | Sedentary | Strenuous |
|-----------|-----------|
| 1. _____  | 1. _____  |
| 2. _____  | 2. _____  |
| 3. _____  | 3. _____  |

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you wear dentures? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ By whom? \_\_\_\_\_

Does anyone else in your family suffer from this or a similar condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Many of our patients plan to file for insurance benefits for the care they receive in our office. If you have insurance, please include the name and type of coverage below. If you would like, we will check with the company to determine your eligibility for benefits and what they are.

Insurance Company \_\_\_\_\_

Type of coverage:

\_\_\_\_\_ Workman's Comp. \_\_\_\_\_ Personal Liability (Negligent Party) \_\_\_\_\_ Comp. Med. Pay \_\_\_\_\_ Homeowner's \_\_\_\_\_ Group Health \_\_\_\_\_ Other

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Richard L. Hilton 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 Dr. Richard L. Hilton will be credited to my account upon 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 care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

Information taken by \_\_\_\_\_