SAN JACINTO
CHIROPRACTIC
and Wellness Center

Confidential Patient Health Record

Today's Date: _____/_____/_____

How did you hear about us? ☐ **Close to home/work** ☐ **Yellow pages** ☐ **Drove by** ☐ **Hospital** ☐ **Insurance Plan**
☐ **Family** _____ ☐ **Friend** _____
☐ **Co-Worker** _____ ☐ **Dr.** _____

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** **Suffix:** ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Last:_____ **First:**_____ **Middle:** _____

Birth Date: _____ /_____/_____ **Age:**_____ **Sex: M / F** **SSN:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Home Phone: (_____**)** _____-_____ **Work Phone: (**_____**)** _____-_____ **Ext** _____

Cell Phone: (_____**)** _____-_____ **Fax #: (**_____**)** _____-_____

E-mail Address: _____

What is the reason for your visit?

_____

Emergency Contact

Last:_____ **First:**_____ **Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____**)** _____-_____ **Cell Phone: (**_____**)** _____-_____

Work Phone: (_____**)** _____-_____ **Ext** _____

Employment Information

Business Name: _____

Phone: (_____**)** _____ - _____ **Fax #: (**_____**)** _____ - _____

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor**

Doctor's Name: _____ **Location:** _____ **Date of Last Visit:** _____

Primary Care Physician(s): List ANY/ALL physicians you are CURRENTLY being treated by. Be Specific.

_____ **Phone:** _____

Current Medication(s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	For how long?

Patient Name: _____ Date:_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment but they must be answered carefully as the problems can affect your overall course of care. Check any that apply to you.

Constitutional:

□ chills	□ fatigue	□ night sweats	□ weight loss
□ daytime drowsiness	□ fever	□ weight gain	

Eyes/Vision:

□ blindness	□ change in vision	□ field cuts	□ photophobia
□ blurred vision	□ double vision	□ glaucoma	□ tearing
□ cataracts	□ eye pain	□ itching	□ wear glasses/contacts

Ears, Nose and Throat:

□ bleeding	□ ear drainage	□ hearing loss	□ nosebleeds	□ sore throat
□ dentures	□ ear pain	□ history of head injury	□ postnasal drip	□ ringing in ears
□ hard to swallow	□ fainting	□ hoarseness	□ runny nose	□ TMJ problems
□ discharge	□ frequent sore throats	□ loss of sense of smell	□ sinus infections	
□ dizziness	□ headaches	□ nasal congestion	□ snoring	

Respiration:

□ asthma	□ coughing up blood	□ sputum production
□ cough	□ shortness of breath	□ wheezing

Cardiovascular:

□ chest pain or discomfort	□ high blood pressure	□ shortness of breath
□ chest pain	□ low blood pressure	□ swelling of legs
□ leg pain/ache	□ difficulty breathing lying down	□ ulcers
□ heart murmur	□ palpitations	□ varicose veins
□ heart problems	□ waking at night w/ shortness of breath	

Gastrointestinal:

□ abdominal pain	□ diarrhea	□ indigestion	□ abnormal stool size	□ vomiting blood
□ belching	□ difficulty swallowing	□ jaundice	□ abnormal stool color	
□ black - tarry stools	□ heartburn	□ nausea	□ abnormal stool texture	
□ constipation	□ hemorrhoids	□ rectal bleeding	□ vomiting	

Female:

□ birth control	□ cramps	□ irregular menstruation	□ vaginal bleeding
□ breast lumps/pain	□ frequent urination	□ pregnancy	□ vaginal discharge
□ burning urination	□ hormone therapy	□ urine retention	

Male:

□ burning urination	□ frequent urination	□ prostate problems
□ erectile dysfunction	□ hesitancy/ dribbling	□ urine retention

Endocrine:

□ cold intolerance	□ excessive hunger	□ goiter	□ unusual hair growth
□ diabetes	□ excessive thirst	□ hair loss	□ voice changes
□ excessive appetite	□ abnormal frequency of urination	□ heat intolerance	

Patient Name: _____ Date:_____

Skin:

□ changes in nail texture □ hair loss □ skin itching □ skin lesions / ulcers
□ changes in skin color □ hives □ skin tingling □ varicose veins
□ hair growth □ history of skin disorders □ rash

Nervous System:

□ dizziness □ limb weakness □ numbness □ slurred speech □ tremor
□ facial weakness □ loss of consciousness □ seizures □ stress □ unsteadiness of gait/ loss of balance
□ headache □ loss of memory □ sleep disturbance □ strokes

Psychologic:

□ loss or change in appetite □ confusion □ insomnia □ memory loss
□ anxiety □ bi-polar disorder □ depression □ mood change

Allergy:

□ trouble breathing □ itching □ chronic nasal congestion □ sneezing
□ food intolerance □ acute nasal congestion □ rash

Hematologic:

□ anemia □ blood clotting □ bruising easily □ lymph node swelling
□ bleeding □ blood transfusion □ fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for This Condition:

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment helpful? □ Yes □ No

Explain: _____

***Childhood Illness (es):* CHECK all CURRENT conditions.**

□ ADD □ chicken pox □ headaches □ scoliosis
□ atopic dermatitis (eczema) □ crohn's/colitis □ hepatitis □ seizure disorder
□ allergies/hayfever □ depression □ HIV □ sickle cell anemia
□ anemia □ diabetes □ measles □ spina bifida
□ asthma □ ear infections □ mumps □ other:
□ bedwetting □ fetal drug exposure □ psoriasis
□ cerebral palsy □ food allergies (list below) □ rash

***Adult Illness(es):* CHECK all CURRENT conditions.**

□ ADD □ cystic kidney disease □ hypertension □ psychiatric problems
□ alzheimers □ depression □ influenzal pneumonia □ scoliosis
□ anemia □ diabetes (insulin dep) □ liver disease □ seizures
□ arthritis □ diabetes (non insulin) □ lung disease □ shingles
□ asthma □ eczema □ lupus erythema (discoid) □ past history of similar symptoms
□ cancer □ emphysema □ lupus erythema (systemic) □ STD's (unspecified)
□ cerebral palsy □ eye problems □ multiple sclerosis □ suicide attempt(s)
□ chicken pox □ fibromyalgia □ parkinson's disease □ thyroid problems
□ crohn's/colitis □ heart disease □ unspecified pleural effusion □ vertigo

Patient Name: _____ Date:_____

□ **CRPS (RSD)** □ **hepatitis** □ **pneumonia** □ **other:**
□ **CVA (stroke)** □ **HIV** □ **psoriasis**

Surgery (ies): CHECK all that apply and **WRITE the DATE of the Procedure immediately afterward.**

□ **angioplasty**	□ **cosmetic**	□ **hysterectomy**	□ **pacemaker insertion**
□ **appendectomy**	□ **D & C**	□ **joint reconstruction**	□ **rotator cuff**
□ **caesarian section**	□ **dental surgery**	□ **joint replacement**	□ **spinal fusion**
□ **cardiac catheterization**	□ **gall bladder**	□ **knee repair**	□ **tonsilectomy**
□ **carpal tunnel repair**	□ **hemorrhoidectomy**	□ **laminectomy**	□ **other:**
□ **coronary artery bypass**	□ **hernia repair**	□ **mastectomy**	

Injury (ies): **CHECK all that apply and WRITE the DATE of the Injury immediately afterward.**

□ **back injury**	□ **head injury (loss of consciousness)**	□ **motor vehicle accident**
□ **broken bones**	□ **head injury (no loss of consciousness)**	□ **soft tissue injury (mild)**
□ **disability (ies)**	□ **industrial accident**	□ **soft tissue injury (moderate)**
□ **fall (severe)**	□ **joint injury**	□ **soft tissue injury (severe)**
□ **fracture**	□ **laceration (severe)**	□ **other:**

Family History: **CHECK all that apply. LIST any specific conditions past or present after has/had:**

father	□ **alive**	□ **deceased**	□ **normally developed**	□ **no significant disease**	□ **has/had:**_____
mother	□ **alive**	□ **deceased**	□ **normally developed**	□ **no significant disease**	□ **has/had:**_____
son (s)	□ **alive**	□ **deceased**	□ **normally developed**	□ **no significant disease**	□ **has/had:**_____
daughter(s)	□ **alive**	□ **deceased**	□ **normally developed**	□ **no significant disease**	□ **has/had:** _____
brother(s)	□ **alive**	□ **deceased**	□ **normally developed**	□ **no significant disease**	□ **has/had:** _____
sister(s)	□ **alive**	□ **deceased**	□ **normally developed**	□ **no significant disease**	□ **has/had:**_____

Insurance Information:

Who Is Responsible For Your Bill? **YOU and… (mark appropriate box(es))** □ **Myself ONLY**

□ **Spouse** □ **Worker's Comp** □ **Auto Insurance** □ **Medicare** □ **Medicaid** □ **Other (be specific):**_____

Personal Health Insurance Carrier: _____ **Health ID Card #:** _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Date of Birth: _____-_____-_____ **Primary Care Physician:** _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □**Yes** □ **No** **Date:**____/____/_____**Time:** _____**am/pm**

Carrier: _____ **Policy #** _____

Carriers Phone #: (_____) _____-_____ **Adjuster:** _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____

Patient's Signature: _____ **Date:** _____

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ **Date:** _____ **Dr:** _____

Describe Chief Complaint: _____

_____

Body Area(s) Involved: ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back

☐ Shoulder/Elbow/Wrist/Hand ☐ Hip/Knee/Ankle/Foot

Condition: ☐ Acute (less than 6 weeks old) ☐ Chronic (older than 6 weeks) ☐ Last Occurred: _____

Mechanism of Onset:

☐ **Auto:** [☐ Driver/Passenger ☐ On Foot Struck By Vehicle (refer to completed auto accident history form)]

☐ **Work Related:** [☐ Fall ☐ Falling Object ☐ Lifting ☐ Repetitive Motion ☐ Other: _____]

☐ **Other – Legal Action:** [☐ Slip and Fall ☐ Other: _____]

☐ **Other – No Fault:** [☐ Cause Unknown ☐ Overexertion ☐ Repetitive Motion ☐ Slept Wrong ☐ Slip and Fall]

Description of Onset of Complaint: _____

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Both Sides _____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Traveling to Another Area ☐ Sharp

☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

Circle Level of Disability Due to Symptoms (Resting):

0 None **1 2 3 4 5 6 7 8 9 10** Complete

Circle Level of Disability Due to Symptoms (With Activity):

0 None **1 2 3 4 5 6 7 8 9 10** Complete

Duration: Started: _____ ☐ Hours Ago ☐ Days Ago ☐ Weeks Ago ☐ Months Ago ☐ Years Ago

Worsened: _____ ☐ Hours Ago ☐ Days Ago ☐ Weeks Ago ☐ Months Ago ☐ Years Ago

Injury/Accident Occurred:_____

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Movement; *Pain is:* ☐ Constant ☐ Off and On

Context: *Better with:* ☐ Warm Temp ☐ Cold Temp; *Worse with:* ☐ Warm Temp ☐ Cold Temp ☐ Damp

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing

☐ Tingling ☐ Nausea ☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Headaches: Location: ☐ Back of Head ☐ Front of Head ☐ Top of Head ☐ Left Temple ☐ Right Temple ☐ Face

Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Vision Changes ☐ With Runny Nose

Time of Day: _____ Occurs: _____ Times Per: _____ Lasts: _____ Minutes/Hours

Sensation Travels to Area: Left / Right / Both Sides _____

Weakness of Movement: Left / Right / Both Sides _____

Other Assoc Signs and Symptoms:

☐ aches	☐ burning	☐ cold arms/legs	☐ difficulty walking	☐ dizziness
☐ bruising	☐ chronic fatigue	☐ fever	☐ heartburn	☐ joint stiffness
☐ muscle spasm	☐ muscle weakness	☐ nausea	☐ numbness	☐ pale skin
☐ panic	☐ pins & needles	☐ runny nose	☐ shortness of breath	☐ sweating
☐ swelling	☐ tingling	☐ vomiting		

Modifying Factors:

Symptoms Better:	☐ nothing helps	☐ activity	☐ bending	☐ ice	☐ heat
	☐ massage	☐ movement	☐ OTC meds	☐ prescribed meds	☐ rest
	☐ stretching	☐ sitting	☐ standing	☐ twisting	☐ walking

Daily Activities: Effects of Current Condition on Performance

Bending:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Care of Sick Family:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Carrying Groceries:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Moving Sit to Stand:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Climb Stairs:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Driving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Computer Use:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Eating:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Household Chores:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Kneeling:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Lifting Children:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Lifting Other:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Pet Care:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Reading/Concentration:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Self Care–Bathing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Self Care–Dressing:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Self Care–Shaving:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Sexual Activities:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Sleep:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Sitting Still:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Standing Still:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Walking:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform
Yard Work:	No Effect	Mild Painful (Can do)	Mod Painful (Limited)	Severe Unable to Perform

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Job Classification: ☐ **Sedentary** (lift<5lbs) ☐ **Light** (lift 5-20lbs**)** ☐ **Mod** (lift 20-50lbs) ☐ **Heavy** (lift>50 lbs)

Lifting Frequency: ☐ **Constant** (67-100%/day**)** ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)

Lifting Postures: ☐ **With Arms** ☐ **With Legs** ☐ **When Bending** ☐ **When Standing** ☐ **Overhead**

Work Activity Postures: (hrs/day)

☐ **bending: _____h/d** ☐ **climbing: _____h/d** ☐ **kneeling: _____h/d** ☐ **pulling: _____h/d** ☐ **pushing: _____h/d**

☐ **reaching: _____h/d** ☐ **sitting: _____h/d** ☐ **standing: _____h/d** ☐ **twisting: _____h/d** ☐ **walking: _____h/d**

Repetitive Activities: (hrs/day)

☐ **assembly/fine manipulation: _____h/d** ☐ **computer use/typing: _____ h/d** ☐ **grasping: _____ h/d**

☐ **hand tool use: _____ h/d** ☐ **operation of machinery controls: _____ h/d** ☐ **phone use: _____h/d**

Condition's Effect On Job Performance:

Mild Painful (Can do) **Moderate** Painful (limited ability) **Moderate/Severe (**Limited Duty) **Severe** (Cannot perform duties)

Recreational Activity: Effects of Current Condition on Performance

_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

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