

For office use only

Name _____

Date _____

Case Number _____

PATIENT HEALTH RECORD



CHIROPRACTIC WORKS
OF PARK CITY

Patient Information

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
Email Address _____
Birth date _____ Age _____
Gender Male Female Number of Children _____
Employer _____
Work Address _____
City _____ State _____ Zip _____
Work Phone _____ Type of Work _____
Marital Status Married Single Divorced Separated Widowed
Payment Method Cash Check Credit Card # _____ Expiration _____

Spousal or Parental Information

Name _____
Employer _____
Work Phone _____
Type of Work _____

Reason for this visit

Describe the purpose of this visit _____
Is the reason for this visit related to: Job Sports Auto Fall Chronic Discomfort Home Injury Other
If other, please explain _____
If job related, have you made a report of your accident to your employer? Yes No
When did this condition begin _____
Has the condition Gotten worse Stayed constant Comes and goes
Does the condition interfere with Work Sleep Daily routine Other activities
Has this condition occurred before Yes No Explain _____
Have you seen other doctors for this condition? Yes No
Doctor's Name _____ Type of Treatment _____
Results _____

Chiropractic Experience

Who referred you to this office _____
Have you been adjusted by a chiropractor before Yes No
Reasons for those visits _____
Doctor's Name _____ Approximate date of last visit _____
Has any adult in your family seen a Chiropractor Yes No Has any child in your family seen a Chiropractor Yes No

Goals for my care

There are many reasons that people see a Chiropractor. Some are in need of pain relief, some are looking to correct the causes of their pain and others are looking to correct other issues occurring in their bodies. When recommending a treatment program, we will be conscious of your needs and desires. Please check the type of care that you desire so we can remain as sensitive as possible to your wishes.

- Relief Care** - Symptomatic relief of pain or discomfort
- Corrective Care** - Correcting the cause of the problem while also treating the symptoms
- Comprehensive Care** - Treat what ever issue is malfunctioning in the body to the highest state of health
- Recommended Care** - I want the doctor to suggest the most appropriate care for my condition

Patients signature

Date

Health Conditions

Please check any of the following conditions that you have now, or have had in the past. While they may seem unrelated to your current condition, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|--|--|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart attack/Stroke | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Heart surgery/Pacemaker | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pain between the shoulders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Numbness or pain in arms/legs/hands | <input type="checkbox"/> Alcohol/Drug abuse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Thyroid problems |

For women

Are you pregnant Yes No Are you nursing Yes No Are you taking birth control Yes No

Do you experience painful periods Yes No Do you have irregular cycles Yes No

Do you have breast implants Yes No

Medications

- | | | | | |
|--|-------------------------------------|---|--|--|
| <input type="checkbox"/> Nerve pills | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Pain killers (including aspirin) | <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood pressure medication | <input type="checkbox"/> Insulin | <input type="checkbox"/> Blood thinners | | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | | | |

Health Habits

Do you smoke No Yes _____ packs/day Do you drink alcohol No Yes _____ drinks/day

Do you drink coffee No Yes _____ cups/day Do you exercise regularly No Moderate Daily

Do you wear Heel lifts Sole lifts Inner soles Arch supports

Authorization for care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patients signature

Date

Guardian or Spouse's signature authorizing care

Date

Who should receive bills for payment on your account

- Patient Spouse Parent Worker's Comp Auto Insurance
 Medicare Medicaid Personal Health Insurance

Emergency contact

Name _____ Relationship _____

Work phone _____ Home phone _____ Cell phone _____



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