Great Lakes Chiropractic Confidential Patient Health Record

Name _____ Sex: M F Marital Status: M S W D

Address _____ Date of Birth: _____ Age:_____

City: _____ State _____ Zip _____ Phone # _____

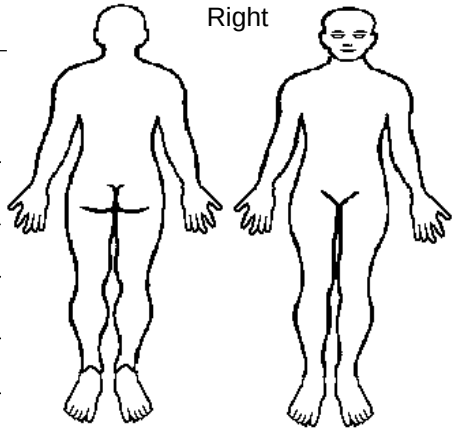
SS# _____ - _____ - _____ Spouse Name:_____ # Children_____

Employer _____Occupation:_____ Work Phone:_____

Primary Physician: _____ Last Exam: _____

How did you hear about us: □ Referred By: _____ □ Newspaper
□ Shoppers □ Phone book □ Website □ other_____

Was this accident/injury a result of: Auto Work Other **DATE OF INJURY:**_____



Describe injury or complaint and what you think caused it:

_____

_____

_____

_____

_____

List other doctors consulted for this condition(s):

Dr. Name: When consulted _____

Diagnosis: _____

Treatment: _____

Circle the number that best describes the level of your pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Pain Moderate Pain Severe Pain

List serious accidents, falls or broken bones: _____

_____

When:_____

Were you ever knocked unconscious? ☐ Yes ☐ No

Explain:_____

Habits

Have you ever smoked? No / Yes packs / day _____ years _____

Coffee: _____ cups per day

Sleep: _____ hours per night

Exercise: _____ times per week

Family History please (**X**) appropriate box

	Diabetes	Heart	Kidney	Cancer	Back
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Brother # of _____	☐	☐	☐	☐	☐
Sister # of _____	☐	☐	☐	☐	☐

Please list the medications and vitamins or food supplements you are taking: *(prescription drugs, birth control, over the counter drugs)*

1.	For:	Approximately how long?
2.	For:	Approximately how long?
3.	For:	Approximately how long?
4.	For:	Approximately how long?
5.	For:	Approximately how long?
6.	For:	Approximately how long?

List Allergies: (medicine, dust, ragweed, certain foods)

1. 2.

3. 4.

Check* (X) *any of the following illnesses or diseases you have or have had:

- ☐ Diabetes
- ☐ Cancer
- ☐ Heart attack
- ☐ Stroke
- ☐ Kidney stones
- ☐ Prostate problem
- ☐ Chicken pox
- ☐ Polio
- ☐ Appendicitis
- ☐ Chronic cough
- ☐ Measles
- ☐ Mumps
- ☐ High cholesterol
- ☐ Tuberculosis
- ☐ Rheumatoid arthritis
- ☐ Anemia
- ☐ Goiter
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Influenza
- ☐ Whooping cough
- ☐ Epilepsy
- ☐ Pleurisy
- ☐ Pneumonia

NECK, BACK, EXTREMITY *Check* (X) *conditions you presently have or have had in the <u>past year</u>*

Neck & Shoulders
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Grinding/popping sounds in neck

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

Arms & Hands
- ☐ Pain down arm
- ☐ Pain/numbness in hand

Hips, Legs & Feet
- ☐ Pain in buttocks
- ☐ Pain/numbness down leg

Low-Back ☐ Low back pain ☐ Low back stiffness

GENERAL SYMPTOMS *Check* (X) *conditions you presently have or have had in the <u>past year</u>.*

General
- ☐ Fever
- ☐ Headache
- ☐ Migraine headaches
- ☐ Loss of weight
- ☐ Weight gain

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Blood in stool

Eye, Ear, Nose, Throat
- ☐ Blurred vision
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Dizziness

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Difficulty starting and/ or stopping urine

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

Women Only
- ☐ Menstrual pain
- ☐ Abnormal bleeding

Are you pregnant? ☐ Yes ☐ No ☐ not sure

☐ Menopause When?

Please list the surgeries and hospitalizations that you have had and their approximate dates:

1.	Date:	Doctor:
2.	Date:	Doctor:
3.	Date:	Doctor:
4.	Date:	Doctor:
5.	Date:	Doctor:
6.	Date:	Doctor:

List past illnesses: (heart attack, thyroid, kidney etc.)

1.	Date:
2.	Date:

I certify that the information on this form is true and accurate to the best of my knowledge. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from any doctor or assistant at Great Lakes Chiropractic.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian's Signature Authorizing Care Date