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:____________________

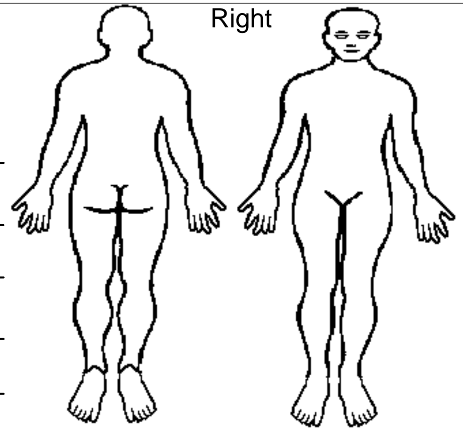
Primary Physician: ______________________________ Last Exam: ____________________

In Case of Emergency ____________________Relationship______________Phone______________

How did you hear about us?: ○ Referred by____________________ ○ Newspaper ○ Shoppers ○ Website

May we use your name in thanking them ○ Yes ○ No ○ other ____________________ ○ Sign

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



Describe injury or complaint and what you think caused it:

____

____

____

____

____

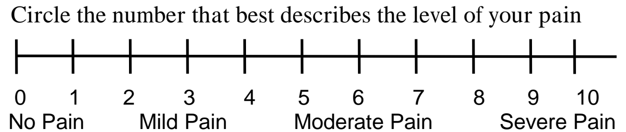
List other doctors consulted for this condition(s):

Dr. Name: When consulted ______________________________

Diagnosis: ______________________________

Treatment: ______________________________

Circle the number that best describes the level of your pain



List serious accidents, falls or broken bones: ______________________________ When ______________

Have you ever been knocked unconscious? ☐ yes ☐ no Explain: ______________________________

Habits

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

Have you ever used tobacco? No / Yes

Exercise: ________ times per week

Sleep: ________ hours per night

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?

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List Allergies: (medicine, dust, ragweed, certain foods) ☐ None known

1. 2.

3. 4.

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

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

NECK, BACK, EXTREMITY Check (X) conditions you presently have or have had in the past year

Neck & Shoulders	Mid-Back	Arms & Hands	Hips, Legs & Feet
☐ Pain in neck	☐ Mid-back pain	☐ Pain down arm	☐ Pain in buttocks
☐ Neck stiffness	☐ Pain between shoulder blades	☐ Pain/numbness in hand	☐ Pain/numb down leg
☐ Grinding/popping sounds in neck	☐ Mid-back stiffness		☐ Low back pain
			☐ Low back stiffness

GENERAL SYMPTOMS Check (X) conditions you presently have or have had in the past year.

General	Gastrointestinal	Eye, Ear, Nose, Throat	Genito-Urinary
☐ Fever	☐ Constipation	☐ Blurred vision	☐ Blood in urine
☐ Headache	☐ Diarrhea	☐ Earache	☐ Frequent urination
☐ Migraine headaches	☐ Excessive thirst	☐ Loss of hearing	☐ Painful urination
☐ Loss of weight	☐ Stomach pain	☐ Ringing in ears	☐ Difficulty starting stopping urine
☐ Weight gain	☐ Ulcers	☐ Nosebleeds	
	☐ Blood in stool	☐ Dizziness	

Cardiovascular	Women Only	
☐ Chest pain	Are you pregnant?	☐ Yes ☐ No ☐ not sure
☐ High blood pressure	☐ Menstrual pain	☐ Menopause
☐ Low blood pressure	☐ Abnormal bleeding	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 / Legal guardian signature Date

Person responsible for patient (please print) DOB Social Security #