

Confidential Patient Health Record

Today's Date: ____ / ____ / ____

How did you hear about us?

- Family
 Doctor
 Drove by
 Close to home / work

- Friend / Coworker
 Radio / Media
 Insurance Plan
 Other

Personal Information

Last name _____ First name _____ Middle Initial _____
 DOB _____ Age _____ Sex _____ Social Security # _____
 Address _____ Apt # _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ Fax Number _____
 Work Email _____ Spouses Name _____
 Home Email _____ Which Email _____

Emergency Contact

Last name _____ First name _____
 Address _____ Apt # _____
 City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Email Address _____ Relationship _____
 Verification Question _____

Verification Question (Must be 6 Characters Long):

Explain you Chief Compliant

Please Tell Us More About Your Chief Complaint. Is Your Chief Complaint in your:

- Neck Low Back Mid Back Arm / Hands Leg / Feet

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What other complaints are you having? _____

Is this condition New (or) Chronic

Rate the intensity of the pain (1 being no pain and 10 being very severe pain) _____

When did you first notice the pain? _____

Do you feel the symptom(s)

76 - 100% 51- 75% 26 - 50% 1 – 25%

Is it Worse?

in the morning mid day end of day/night throughout the day at night

Location – Check all the apply

Left Shoulder Right Shoulder Both Shoulders Upper Arm Arm to Hand
 Upper Leg Lower Leg Leg Buttocks

Describe the Symptoms (Check all that apply)

Dull Sharp Throbbing Burning Deep Aching
 Tingling Stabbing Cramping Numbness

Symptoms are aggravated by (Check all that apply)

Sitting Standing Walking Bending Deep Aching
 Sleeping Sneezing Coughing Reaching Twisting

Symptoms are relieved by (Check all that apply)

Sitting Standing Lying Down Bend Knees Leaning
 No Movement Pain Medicine Heat Ice Topical

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Miscellaneous Information

Do you want electronic copies of your record Summaries?

	No	(or)		Yes
	No	(or)		Yes

Do you smoke tobacco?

If yes how often do you smoke?

If yes, what is your interest in quitting smoking? (Rate from 1 to 10) :

Current Medication(s) List any and all medications you are currently taking. Be Specific

Medication	Dosage	For What Condition	Time On Medication

List any known allergies:

Briefly list your main health problems:

Has a doctor diagnosed you with Hypertension presently?

	No	(or)		Yes
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Has a doctor diagnosed you with Diabetes?

	No	(or)		Yes
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If yes to Diabetes, was your hemoglobin A1c > 9.0%?

	No	(or)		Yes
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Have you had an X-Ray, CT scan or MRI of your low back spine in past 28 days?

	No	(or)		Yes
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Employee Status

<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Other
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Race

<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> I choose not to specify
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Language

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Sign Language	<input type="checkbox"/> Other: _____
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Preferred Language

<input type="checkbox"/> Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Other
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Multi Racial

<input type="checkbox"/> No	(or)	<input type="checkbox"/> Yes
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Ethnicity (check one)

<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> I choose not to specify
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