

Confidential Patient Health Record

Today's Date: ___ / ___ / ___

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

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. other: _____

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

Suffix: Jr Sr II III MD PhD DO Esq PA RN BSN other: _____

Birth Date: ___ / ___ / ___ **Age:** _____ **Sex:** Male / Female **Social Security #:** _____ - _____ - _____

Primary Language: English French German Spanish other: _____

Driver's License #: _____ **State:** _____

Blood Type: A positive A negative B positive B negative AB positive AB negative O positive O negative

Race: African American Asian Caucasian Hispanic Multiracial Native American Other: _____

Marital Status: Single Married Widowed Divorced Separated

Eye Color: blue brown green grey hazel other: _____

Hair Color: black blonde brown gray red white other: _____

Address: _____ **Apt #** _____

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

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

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

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Emergency Contact

Title: Miss Mrs. Ms. Master Mr. Dr. Prof. Rev. other: _____

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

Suffix: Jr Sr II III MD PhD DO Esq PA RN BSN other: _____

Address: _____ **Apt #** _____

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

Relationship: Spouse Relative Friend Other _____

Email Address: _____

Birth Date: ___ / ___ / ___ **Social Security #:** _____ - _____ - _____

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

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

Employment Information

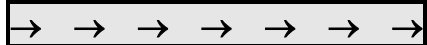
Business Name: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Employer's Email Address: _____
Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

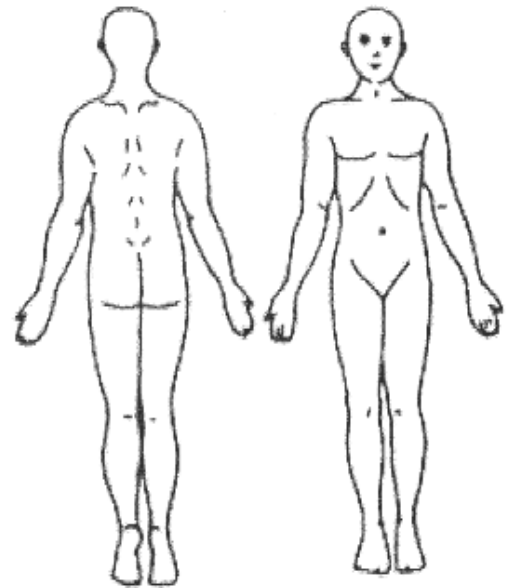
Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

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

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

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

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- bleeding
- ear drainage
- hearing loss
- nosebleeds
- sore throat
- dentures
- ear pain
- history of head injury
- postnasal drip
- tinnitus (ringing in ears)
- difficulty swallowing
- fainting
- hoarseness
- rhinorrhea (runny nose)
- TMJ problems
- discharge
- frequent sore throats
- loss of sense of smell
- sinus infections
- dizziness
- headaches
- nasal congestion
- snoring

Respiration: I DENY having any of the symptoms or problems listed below.

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

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort)
- high blood pressure
- shortness of breath with exertion or exercise
- chest pain
- low blood pressure
- swelling of legs
- claudication (leg pain/ache)
- orthopnea (difficulty breathing lying down)
- ulcers
- heart murmur
- palpitations
- varicose veins
- heart problems
- paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

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

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

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

Male: I DENY having any of the symptoms or problems listed below.

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

Endocrine: I DENY having any of the symptoms or problems listed below.

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

Skin: I DENY having any of the symptoms or problems listed below.

- changes in nail texture
- hair loss
- itching
- skin lesions / ulcers
- changes in skin color
- hives
- paresthesias
- varicosities
- hair growth
- history of skin disorders
- rash

Nervous System: I DENY having any of the symptoms or problems listed below.

- 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: I DENY having any of the symptoms or problems listed below.

- anhedonia
- behavioral change
- convulsions
- memory loss

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

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis itching chronic nasal congestion sneezing
 food intolerance acute nasal congestion rash

Hematologic: I DENY having any of the symptoms or problems listed below.

- 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 Same Condition: I have not previously seen a doctor for this condition OR Fill in the information BELOW

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

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

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

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

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

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE 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

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE 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
- CRPS (RSD)
- hepatitis
- pneumonia
- other:
- CVA (stroke)
- HIV
- psoriasis

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

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

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

Menstrual History.

I... <input type="checkbox"/> currently have menses.	<input type="checkbox"/> currently DO NOT have menses.
My menses... <input type="checkbox"/> are regular.	<input type="checkbox"/> are NOT regular.
_____ Age of first menses	_____ Age when metaphase began
Date of last menses: ____/____/_____	

Injury (ies): Mark or List All Injuries. 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:

Immunizations: Please list the date(s) next to the immunization, if known.

- adenovirus
- hepatitis C
- pertussis
- tuberculosis
- anthrax
- influenza
- pneumococcal
- tularemia

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> botulism | <input type="checkbox"/> IPV (polio) | <input type="checkbox"/> pneumovax | <input type="checkbox"/> typhoid |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> PPD (mantoux test- TB) | <input type="checkbox"/> varivax (chicken pox) |
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> lyme disease | <input type="checkbox"/> rabies | <input type="checkbox"/> whooping cough (pertussis) |
| <input type="checkbox"/> flu | <input type="checkbox"/> measles | <input type="checkbox"/> rotavirus | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> haemophilus B | <input type="checkbox"/> meningococcal | <input type="checkbox"/> rubella | <input type="checkbox"/> other: |
| <input type="checkbox"/> hepatitis A | <input type="checkbox"/> MMR | <input type="checkbox"/> smallpox | |
| <input type="checkbox"/> hepatitis B | <input type="checkbox"/> mumps | <input type="checkbox"/> tetanus | |

Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> dairy | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> other: | | | |

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

- | | | | |
|----------------|-------------------|---------------|-------------------------|
| 1. angioedema | 3. GI disturbance | 5. joint pain | 7. shortness of breath |
| 2. anaphylaxis | 4. headache | 6. rash | 8. unspecified reaction |

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

- | | | | | | |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Social History: Mark all that apply below.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
 beer liquor wine; quantity of _____ oz./glasses per day week month

My Dietary Intake consists mainly of the following: (mark all that apply)

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> high fat | <input type="checkbox"/> high salt | <input type="checkbox"/> low fiber |
| <input type="checkbox"/> high fiber | <input type="checkbox"/> low calorie | <input type="checkbox"/> low salt |
| <input type="checkbox"/> high protein | <input type="checkbox"/> low carbohydrate | <input type="checkbox"/> low sugar |

Mark the highest level of Education completed:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> pre-school | <input type="checkbox"/> high school | <input type="checkbox"/> college | <input type="checkbox"/> doctorate |
| <input type="checkbox"/> elementary school | <input type="checkbox"/> high school graduate | <input type="checkbox"/> college graduate | <input type="checkbox"/> graduate school |
| <input type="checkbox"/> middle school | <input type="checkbox"/> GED | <input type="checkbox"/> associates degree | <input type="checkbox"/> graduate degree |
| <input type="checkbox"/> vocational school | <input type="checkbox"/> high school – incomplete | <input type="checkbox"/> bachelors degree | <input type="checkbox"/> other: _____ |

Substance: never used illegal drugs has not used illegal drugs since _____ .
 never used IV drugs used illegal drugs for _____ (how long?)

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ___/___/___ Time: ___ am/pm

Carrier: _____ Policy # _____

Carrier's Phone #: (____) _____ - _____ Adjuster: _____

Claim #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

X-RAY QUESTIONNAIRE FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time?

Name: _____

- There is a possibility that I may be pregnant at this time
- Yes, I am definitely pregnant
- No, I am not pregnant at this time

I request that x-ray films not be taken because _____

Signature: _____ Date: _____

ONE TIME AUTHORIZATION AGREEMENT (FOR MEDICARE PATIENTS ONLY)

I, _____ Medicare Number _____ request that payment of authorized Medicare benefits be made either to me or on my behalf to RENAISSANCE CHIROPRACTIC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services (formerly known as the HEALTH CARE FINANCING ADMINISTRATION) and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature: _____ Date: _____

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information, and my understanding and my agreement to its terms.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

RENAISSANCE WELLNESS CENTER

Name:

Date:

Condition's Effect On Job Performance: No Effect Mild Painful (Can do) Mod Painful (limited ability)
 Mod/Sev Limited Duty Sev No Limited Duty Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn–Sit-Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Extended Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Kneeling: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading (Concentration): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

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
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform