Date: _____ **Acct. #:** _____

POINTE VILLAGE CHIROPRACTIC
Confidential Health Record

Thank you for choosing Pointe Village Chiropractic for your medical care. Please complete this Health Record, if something does not apply write N/A in the blank.

NAME: _____ BIRTHDATE: _____ AGE: _____
GENDER: ☐ Male ☐ Female MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
RACE: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Middle Eastern
LANGUAGE SPOKEN: _____
ADDRESS: _____
NUMBER & STREET CITY STATE ZIP

Cell phone: _____ Home Phone: _____ Work Phone:_____
E-mail: _____
PREFERRED CONTACT Method: ☐ E-mail ☐ Phone (Cell, Home, Work) ☐ Patient portal
EMERGENCY CONTACT: _____Relationship: _____
Phone:_____
HOW DID YOU HEAR OF OUR OFFICE:

EMPLOYER INFORMATION:
TYPE OF WORK YOU DO:_____
EMPLOYER: _____
EMPLOYER ADDRESS: _____
NUMBER & STREET CITY STATE ZIP

☐ Full-time ☐ Part-time ☐ Homemaker ☐ Retired ☐ Student ☐ Unemployed
☐ 0-20 hrs per week, ☐ 20 to 40 hours per week, ☐ 40 to 50 hours per week, ☐ 60 to 70 hours per week
☐ Mostly sitting, ☐ Mostly standing ☐ Mostly walking,
☐ Light labor ☐ Moderate labor ☐ Heavy labor
☐ Computer work, ☐ Repetitive activities ☐ Heavy telephone use.

_____

Social Habits:

Tobacco use: ☐ light ☐ social ☐ moderate ☐ heavy ☐ non-smoker

Alcohol use: ☐ Social ☐ light ☐ moderate ☐ heavy ☐ Alcoholic ☐ Recovering Alcoholic ☐ Does not drink

Have you used recreational drugs: (M*arijuana, Crack, Cocaine, etc*.)?

☐ Light ☐ moderate ☐ heavy ☐ drug addicted ☐ recovering drug addict

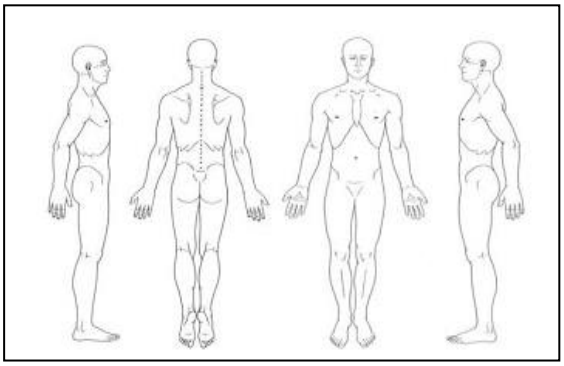
Family History:

	Mother	Father	Sister	Brother
Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐

Patient Name: _____ Date: _____ Acct. #: _____

Chief Complaint: _____

_____



In the area that is affected, indicate on the bodies to the left.
=== Pain
NNN Numbness
TTTT Tingling

WHAT BEST DESCRIBES YOUR SYMPTOMS?

☐ Throbbing	☐ Burning	☐ Cramping	☐ Intermittent
☐ Shooting	☐ Numbing	☐ Dull	☐ Constant
☐ Sharp	☐ Nagging	☐ Aching	☐ Radiating

Severity: No pain 0, worse pain 10: 1 2 3 4 5 6 7 8 9 10

Are these symptoms related to any accidents or falls? ☐ No ☐ Yes, please explain? _____

_____

If this was due to an injury, how were you injured? _____

When did it start: _____ Frequency of Pain: _____

What type of treatment did you receive? _____

Have you had any previous Chiropractic care? ☐ No ☐ Yes, by whom? _____

Do you wear a shoe lift? ☐ No ☐ Yes, ☐ Right ☐ Left

WHAT MAKES YOUR PAIN WORSE?

☐ Athletic Activities	☐ Getting up from a seated position	☐ Personal care/hygiene	☐ Taking care of Family Members
☐ Bending	☐ Grocery shopping	☐ Pulling	☐ Turning head left
☐ Climbing stairs	☐ Headaches	☐ Pushing	☐ Turning head right
☐ Driving	☐ Lifting	☐ Running	☐ Walking
☐ Exercising	☐ Lifting weights	☐ Sitting	☐ Working
☐ Getting in/out of car	☐ Looking down	☐ Sitting at the computer	☐ Sleeping
☐ Getting up from a lying position	☐ Looking up	☐ Standing	☐ Reading

WHAT RELIEVES YOUR PAIN?

☐ Nothing	☐ Deep breathing	☐ Over the counter medications	☐ Sitting
☐ Resting	☐ Exercising	☐ Prescribed medications	☐ Stretching
☐ Chiropractic Adjustments	☐ Hot shower/bath	☐ Resting	☐ Walking
☐ Cold pack	☐ Massage		
	☐ Bending		

PAST MEDICAL HISTORY:

Allergies: _____

SURGICAL HISTORY: _____

MEDICATIONS YOU ARE PRESENTLY TAKING: _____

_____

Are you pregnant? ☐ Yes ☐ No

Patient Name: _____ Date: _____ Acct. #: _____

Number of children? _____ Number of pregnancies ? _____ Number of deliveries? _____

Illnesses:

☐ Cancer
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Migraine headaches
☐ Multiple sclerosis
☐ Diabetes
☐ Hypoglycemia
☐ High Cholesterol
☐ Heart problems
☐ Asthma
☐ Bleed easily
☐ Rheumatoid arthritis
☐ Osteoarthritis
☐ High Blood Pressure

Other conditions: _____

Accidents: Please check all that apply

☐ No previous trauma
☐ Previous automobile accident
☐ Slip and fall
☐ Multiple automobile accidents
☐ Multiple slip and falls
☐ Motorcycle accident
☐ Multiple motorcycle accidents
☐ Boating accident
☐ Multiple Boating accidents

Did any of these accidents cause a permanent injury or disability? ☐ Yes ☐ No
If yes, Please explain:_____
Did any of these accidents result in hospitalization? ☐ Yes ☐ No
If yes please explain: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS?
☐ No symptoms
☐ Decreased activity level
☐ Fever
☐ Chills
☐ Night sweats
☐ Fatigue
☐ Loss of appetite
☐ Weight loss
☐ Weight gain
☐ Loss of energy
☐ Uncontrolled sweating.

PSYCHIATRIC SYMPTOMS?
☐ No Symptoms
☐ Irritability
☐ Depression
☐ Disturbed sleep
☐ Suicidal thoughts
☐ Anxiety
☐ Nervousness

GENITOURINAY SYMPTOMS?
☐ No symptoms
☐ Dysuria (Pain with urination)
☐ Frequent urination
☐ Urgency
☐ Losing control/incontinence
☐ Blood in urine
☐ Bowel dysfunction

ENDOCRINE SYMPTOMS?
☐ No symptoms
☐ Diabetes
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Other thyroid problems

HEAD & ENT SYMPTOMS?
☐ No symptoms
☐ Changes in head dimensions
☐ Blurred or Double vision
☐ Earaches
☐ Recent hearing loss
☐ Chronic ear infections
☐ Hoarseness
☐ Sore throat
☐ Difficulty swallowing

CARDIOVASCULAR SYMPTOMS?
☐ No symptoms
☐ Chest pain
☐ Palpations
☐ Dizziness
☐ Dyspnea (uncomfortable breathing)
☐ Hypertension (high blood pressure)
☐ Hypotension (low blood pressure)
☐ Excessive bruising
☐ Lower extremity edema

RESPIRATORY SYMPTOMS?
☐ No Symptoms
☐ Coughing
☐ Shortness of Breath
☐ Asthma
☐ Apnea
☐ Emphysema
☐ Pneumonia
☐ Wheezing

GASTROINTESTINAL SYMPTOMS
☐ No Symptoms
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Ulcer
☐ Heartburn

MUSCULOSKELETAL SYMPTOMS?
☐ No symptoms
☐ Osteoporosis
☐ Scoliosis
☐ Arthritis
☐ Neck pain
☐ Back problems
☐ Hip disorders
☐ Knee injuries
☐ Foot/Ankle pain
☐ Shoulder problems
☐ Elbow/wrist pain
☐ TMJ issues
☐ Poor posture

INTEGUMENTARY SYMPTOMS?
☐ No Symptoms
☐ Rash
☐ Easy bruising
☐ Gum bleeding
☐ Hyper/Hypo pigmentation
☐ Excessive Acne
☐ Eczema
☐ Psoriasis
☐ Skin cancer
☐ Excessive hair loss

IMMUNOLOGIC SYMPTOMS?
☐ No Symptoms
☐ Enlarged lymph nodes
☐ Hives
☐ Hay fever
☐ Persistent infections

NEUROLOGIC SYMPTOMS?
☐ No Symptoms
☐ Numbness & Tingling
☐ Seizures
☐ Abnormal sensory feelings in extremities
☐ Loss of memory
☐ Trigeminal neuralgia
☐ Neuralgia
☐ Fibromyalgia
☐ Pins and needles feeling

Patient Name: _____ Date: _____ Acct. #: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance proceeds (whether it be all or part of what is due), I personally owe you.

_____ _____

Signature Date