

**Advanced Chiropractic
35 Jackson Street.**

Newnan, Ga. 30263 770-253-5040

Confidential Patient Health Record

Today's Date: _____/_____/_____

Personal Information

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

Last: _____ First: _____ Middle: _____

Address: _____ Apt # _____

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

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

Cell Phone: (_____) _____ - _____ ext _____ Social Security #: _____ - _____ - _____

Birth Date: ____/____/____ Age: _____ Sex: Male / Female

Email Address: _____ Our office has an appointment reminder system using text or email; which do you prefer? (circle one) Email Text --If you choose text we need to know your cell phone carrier; here is the list of cell providers who participate: (circle one) Sprint, NextTel, Verizon, Cingular/AT&T, and T-Mobile

Marital Status: Single Married Widowed Divorced Separated Spouse's Name: _____

Children (Names and Ages): _____

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

How did you hear about us? Family _____ Friend _____
 Co-Worker _____ Insurance Plan Internet/website Yellow Pages Yellow Book
 Drive by Physician _____ Other: _____

Emergency Contact:

Last: _____ First: _____ Middle: _____

Phone: (_____) _____ - _____ ext _____ Relationship: Spouse Relative Friend Other _____

Employment Information

Business Name: _____ Occupation _____

Location _____

Adult Illness(es): Check all health/past conditions. CIRCLE all CURRENT conditions.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | |

Name: _____

Date: ____/____/____

If you have no complaints check the box here and continue at the review of systems section; otherwise, please fill out below as accurately as you possibly can.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

Use the letters BELOW to indicate the TYPE AND LOCATION of your sensations

What is your chief complaint? (WHY YOU ARE HERE): _____

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

When did this Condition BEGIN? ____/____/____

List in your own words how you think your condition started _____

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

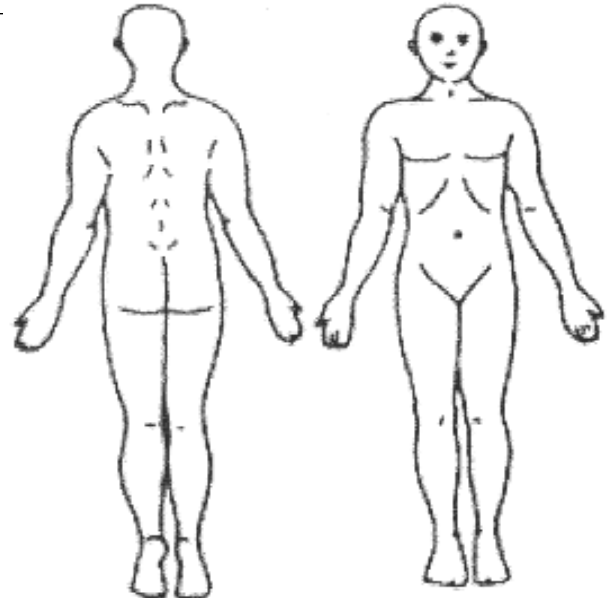
Is the Condition: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Gradual Repetitive Other

Explain: _____

On a scale to 1-10, 10 being severe and 1 minimal how would you rate this symptom? _____

What percentage of the day do you experience the symptom (1-100%)? _____



Please any other major health concerns in order of importance (pains/symptoms/illness/chronic disease)?

		G or S	1-10	1-100%
1) _____	When did it start? _____	Gradual or Sudden _____	Severity _____	Percentage of day _____
2) _____	When did it start? _____	Gradual or Sudden _____	Severity _____	Percentage of day _____
3) _____	When did it start? _____	Gradual or Sudden _____	Severity _____	Percentage of day _____
4) _____	When did it start? _____	Gradual or Sudden _____	Severity _____	Percentage of day _____
5) _____	When did it start? _____	Gradual or Sudden _____	Severity _____	Percentage of day _____

Occupation/Job Title: _____ Work: _____ hrs/week

Description of Work: _____

Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)

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
- Carrying: 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

Name: _____

Date: ____/____/____

- 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
- Lifting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Reading: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- 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
- Sleep: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- 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
- Lying down: **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
- _____ **No Effect** **Mild** Painful(Can do) **Mod** Painful(limited) **Sev** Unable to Perform

Previous Care for this Condition:

Have you seen another professional for THIS CONDITION other than a chiropractor? 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? _____

For how long? _____ Approximately how many visits? _____

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

Name: _____

Date: ____/____/____

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

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

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

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |

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

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

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

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool caliber | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

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

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

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

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> hair growth | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash | |

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

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> limb weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures | <input type="checkbox"/> stress | <input type="checkbox"/> unsteadiness of gait/ loss of balance |
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of memory | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |

Name: _____ Date: ____/____/____

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

- inability to experience pleasure 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.

- anaphylaxis 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

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

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 taken?

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 surgery joint replacement spinal fusion
 cardiac catheterization gall bladder knee repair tonsillectomy
 carpal tunnel repair hemorrhoidectomy laminectomy other:
 coronary artery bypass hernia repair mastectomy other:

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
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 menopause began
Date of last menses: ____/____/____	

Name: _____

Date: ____/____/____

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

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)
- disability (ies) industrial accident soft tissue injury (mild)
- fall (severe) joint injury soft tissue injury (moderate)
- fracture laceration (severe) soft tissue injury (severe)
- other:

Family History:

Health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them? _____

Social History: Mark all that apply below.

- Alcohol: do not drink alcohol social consumption only drink regularly, quantity of ____ glasses per ____
- My Dietary Intake consists mainly of the following: (mark all that apply)
 - high fat high salt low fiber low sugar low salt
 - high fiber low carbohydrate
- Tobacco: Do not use tobacco Live with a smoker Quit smoking Smoke/ Chew
- 1) Job Stress: None Moderate Severe
- 2) Family Stress: None Moderate Severe
- 3) Overall Sense of Wellbeing: Pleased Satisfactory Displeased
- 4) How many times per week do you workout? _____
- 5) How many times per week do you eat out? _____
- 6) How many caffeinated beverages do you consume per day? _____
- 7) How many hours on average do you sleep per night? _____
- 8) Would you consider your current lifestyle (check one) healthy or unhealthy?

Auto / Personal Injury: Fill out only if you have been in an accident recently.

Have you filed a report with your insurance? Yes No

Carrier: _____ Policy # _____

Carriers Phone #: (____) _____ - _____ Adjuster: _____ Claim #: _____

Consent to treat:

I hereby state that the information provided by me is accurate and whole.
 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.

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

Guardian Name Print for Authorizing Care: _____

Guardian Signature of Authorizing Care: _____ Date: _____