WHITNEY
CHIROPRACTIC AND MASSAGE THERAPY

Confidential Patient Health Record

Today's Date:____/_____/_____

INSTRUCTIONS – Fill out to the best of your ablitiy, if you have any questions or are unsure about any answers on this form, leave the section blank, and these sections will be reviewed upon meeting with the doctor.

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

Personal Information

Last: _____ **First:** _____ **Middle:** _____ **Sex: Male / Female**

Address: _____**Apt. #** _____

City: _____ **State:** _____ **Zip:** _____ **Birth Date:** _____ /_____/_____ **Age:** _____

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

Cell Phone: (_____) _____-_____ **Email Address:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated Spouse's/ Partner's Name:** _____

Emergency Contact

Name: _____ **Phone:** (_____) _____-_____

Address: _____

Relationship: ☐ **Mother** ☐ **Father** ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Current Health Condition

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

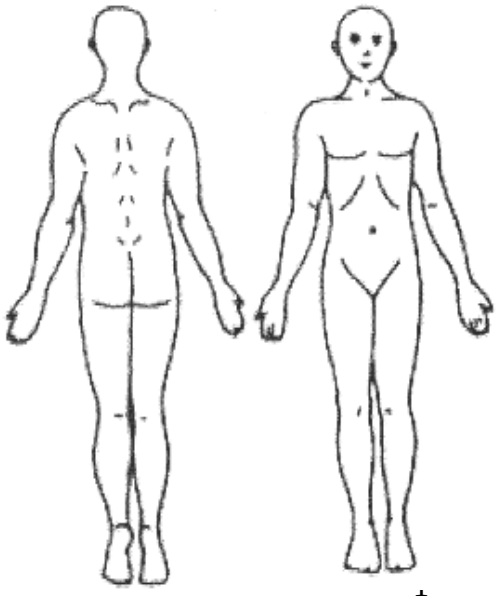
_____

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 T=Tingling S=Stabbing D=Dull



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: _____

Have you seen other doctors or chiropractors for THIS CONDITION? □ Yes □ No.
If yes, who? (Name) _____ Type of Treatment:_____
Were you satisfied with the results of your treatment? □ Yes □ No Explain: _____

Activities of Daily Living- "My condition interferes with….."

My current condition makes the following more difficult (please check all that apply):

□ Carrying Groceries □ Change Position Sit-Stand □ Household Chores
□ Climb Stairs □ Driving □ Extended Computer Use □ Kneeling □ Lifting
□ Reading (Concentration) □ Self Care – Dressing □ Sleep □ Static Sitting
□ Static Standing □ Walking □ Work □ Doing Dishes □ Exercising

Recreational Activity:
Effects of Current Condition on Hobbies or Recreational Activities:
_____

Health Goals: Please List your Top 3
1_____
2_____
3_____

Current Medication (s): **List ANY/ALL prescription & non-prescription you are CURRENTLY taking.**

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

Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Other_____
If Yes, how long? _____ Were they prescribed by a doctor? □ Yes or □ No

Childhood/Adult Illness (es): **LIST all childhood and adult illnesses.**

Surgery (ies) /Hospitalizations: **LIST All Surgical Procedures. Write the DATE of the Procedure as well.**

Injury (ies)/Accidents: **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**
□ disability (ies)	**□ industrial accident**	**□ other:**
□ falls	**□ joint injury**	
□ fracture	**□ laceration (severe)**	

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. Please check all that apply.**

Allergic-Immunologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ hives/eczema	☐ hay fever	☐ catch colds easily	☐ HIV
☐ allergies	☐ frequent sinus trouble	☐ frequent influenza	☐ fever

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

☐ dizziness	☐ high blood pressure	☐ shortness of breath
☐ chest pain	☐ low blood pressure	☐ swollen ankles
☐ high triglycerides	☐ irregular heart beat	☐ past heart attack
☐ murmur	☐ palpitations	☐ varicose veins
☐ fainting spells	☐ high cholesterol	☐ pain down left arm
☐ profuse sweating	☐ difficulty lying flat	☐ pressure over the chest

Constitutional: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ weight loss	☐ fatigue	☐ fever	☐ night sweats

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

☐ vertigo	☐ difficulty hearing	☐ buzzing in ears	☐ ringing in ears	☐ sinus trouble
☐ hearing loss	☐ difficulty swallowing	☐ mouth sores	☐ nosebleeds	☐ dental problems
☐ ear pain	☐ frequent sore throats	☐ hoarseness	☐ nasal stuffiness	☐ _____

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

☐ hot/cold intolerance	☐ hyperthyroidism	☐ goiter	☐ hair loss
☐ diabetes	☐ hypothyroidism	☐ other_____	

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

☐ glasses/contacts	☐ eye pain	☐ cataracts	☐ light bothers eyes
☐ blurred vision	☐ double vision	☐ glaucoma	☐ vision problems

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

☐ heartburn/reflux	☐ nausea/vomiting	☐ change in BMs	☐ blood in stool	☐ constipation
☐ ulcers	☐ abdominal pain	☐ liver problems	☐ burning in stomach	☐ hiatal hernia
☐ black - tarry stools	☐ diarrhea	☐ hepatitis	☐ pancreatitis	☐ jaundice

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

☐ I am currently pregnant	☐ I am NOT pregnant	☐ I am UNSURE if I am pregnant	☐ kidney stones
☐ burning urination	☐ hormone therapy		☐ blood in urine
☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal discharge
☐ breast lumps/pain	☐ frequent urination	☐ kidney infection	☐ incontinence

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

☐ burning urination	☐ frequent urination	☐ prostate problems	☐ incontinence
☐ erectile dysfunction	☐ kidney stones	☐ kidney infection	☐ blood in urine

Hematological: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia	☐ sickle cell anemia	☐ bruising easily	☐ enlarged glands
☐ bleeding disorder	☐ gums bleed easily	☐ lymphoma	☐ _____

Musculoskeletal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ joint pain/swelling	☐ rheumatoid arthritis	☐ stiffness
☐ osteoarthritis	☐ spinal trauma	☐ cancer
☐ back injury	☐ muscle pain	☐ back pain
☐ osteoporosis	☐ scoliosis	☐ head injury
☐ back pain	☐ muscle weakness	☐ broken bones
☐ arthritis	☐ neck pain	☐ compression fracture

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

☐ loss of strength	☐ numbness	☐ headaches	☐ heavy head	☐ tremors
☐ memory loss	☐ lightheaded/dizzy	☐ seizures	☐ migraines	☐ loss of balance
☐ tingling	☐ difficulty speaking	☐ sleep disturbance	☐ past stroke	☐ loss of coordination

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

☐ difficulty sleeping	☐ nervousness	☐ tension	☐ confusion
☐ anxiety	☐ bi-polar disorder	☐ depression	☐ mood swings

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

☐ cough	☐ chest pain	☐ bronchitis	☐ superficial breathing
☐ asthma	☐ chills	☐ pneumonia	☐ difficulty breathing
☐ wheezing	☐ chronic cough	☐ emphysema	☐ lung cancer

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

☐ rash/sores	☐ change in moles	☐ skin problem	☐ slow healing
☐ psoriasis	☐ itching/burning	☐ skin cancer	☐ bruise easily
☐ lesions	☐ change in skin color	☐ scars	☐ _____

Social History: **Mark all that apply below.**

Alcohol: ☐ do not drink alcohol ☐ social consumption only ☐ drink _____regularly
Tobacco: ☐ Do not use tobacco ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker ☐ Quit smoking
☐ Smoke: # ____ per ☐ Day ☐ Week ☐ Month; ☐ Chew: #_____cans per ☐ Day ☐ Week ☐ Year

Employment Information

BusinessName: _____Occupation/JobTitle: _____

Address: _____

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (Mark appropriate box (es)) ☐ Myself ONLY

☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific):_____

Personal Health Insurance Carrier: _____ Health ID card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth : _____ Primary Care Physician: _____

If your condition is a Workers Compensation Injury, Auto Accident, or Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐ No Date: ____/____/_____Time: _____am/pm

Carrier: _____ Policy # _____

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

Claim #: _____

Financial Agreement:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Whitney Chiropractic 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 Whitney Chiropractic 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.

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

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

HIPPA Privacy Notice:

I acknowledge that I have received/reviewed Whitney Chiropractic and Massage's Notice of Privacy Practices (HIPPA) for protected health information. (All of my healthcare records will remain private)

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Informed Consent to Treatment

The Nature of Chiropractic and Massage Treatment: The doctor will use his hands or mechanical devices in order to move your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is inherent in some of the joint manipulation procedures and is a natural effect of joint movement. Various other procedures, including, but not limited to, ice/hot packs, electric stimulation, therapeutic ultrasound, exercises, massage, or other soft tissue therapies may also be used. Physical examination can be physical! It involves the doctor manually challenging your joints and testing your muscle strengths and it can sometimes lead to temporary soreness or worsening of your pain.

Possible Risks and Side Effects: As soon as ANY doctor intervenes with your healthcare there is a risk of side effects and complications. The risk of serious complications from chiropractic treatment has been described as "extremely rare". While less serious complications are possible from chiropractic treatment, most are highly unlikely, but could include fractures, sprains/strains, injury to intervertebral discs, nerves, spinal cord, a worsening of symptoms or development of new symptoms. Cerebrovascular accident such as a stroke is the most serious side effect, but real research data proves that it is very rare, with odds calculated as one in a million to one in forty million, about the same odds of a stroke from having your hair washed in a salon ("beauty parlor syndrome"), and significantly less than the odds of being struck by lightning. Usually, side effects of treatment include transient muscular stiffness or soreness. Some people report it as feeling like they exercised new muscles for the first time. Some procedures (e.g. hot packs or deep tissue massage) could produce skin irritations, burns, or bruises.

Risks of Remaining Untreated: While it is possible that your symptoms can go away with no treatment at all, delay of treatment could reduce body mobility, induce chronic pain, and lessen chances of complete recovery.

I have read the explanation above regarding chiropractic treatment. I have had the opportunity to have questions answered to my satisfaction. I freely decided to undergo the recommended treatment, and hereby give full consent to treatment.

_____ _____

Signature of Patient or Parent/Guardian **Date**

_____ _____

Patient Printed Name **Witness**