

Confidential Patient Health Record

Today's Date: ___ / ___ / ___

How did you hear about us? Family _____ Friend _____ Doctor _____
 Yellow pages Drove by/ Sign Insurance Plan Booklet Internet Google Yahoo Bing Other _____

Personal Information

Title: Mr. Mrs. Ms. Dr.
Last: _____ First: _____ Middle: _____
Suffix: Jr Sr II III
Birth Date: ___ / ___ / ___ Age: _____ Sex: Male / Female SSN: _____ - _____ - _____
Marital Status: Single Married Widowed Divorced Separated Spouse's Name: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____
Home Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Email Address: _____ Alt Email: _____
Children (Names and Ages): _____

Emergency Contact

Last: _____ First: _____ Middle: _____
Relationship: Spouse Relative Friend Other _____
Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____ ext _____

Employment Information

Occupation/ Job Title: _____ Job Description _____
Business Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ - _____ ext _____ Fax #: (_____) _____ - _____
Work Email Address: _____

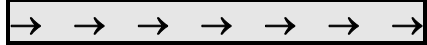
Current Health Condition

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

Patient Name: _____

Date: _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



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: _____

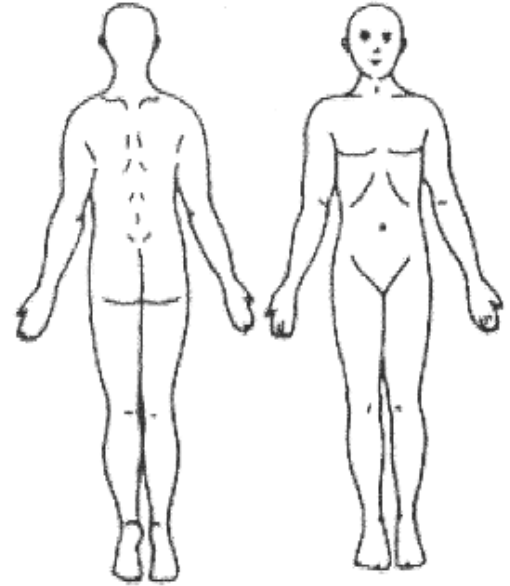
Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Conditions?

Use the letters BELOW to indicate the TYPE and LOCATION of your symptoms right now:
Key: A=Ache B=Burning N=Numbness

P=Pins & Needles S=Sharp D=Dull



REVIEW OF SYSTEMS - Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, please answer these questions 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 TMJ problems
- difficulty swallowing fainting hoarseness rhinorrhea (runny nose) tinnitus (ringing in ears)
- 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

Patient Name: _____

Date: _____

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"/> varicose veins |
| <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"/> shortness of breath |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> paroxysmal nocturnal dyspnea
(waking at night w/ shortness of breath) | <input type="checkbox"/> with exertion or exercise |

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 size | <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 | |

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> cramps | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy | <input type="checkbox"/> urine retention | |
| ___# of pregnancies | ___# of vaginal births | ___# of C-sections | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention |

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 | |

Neurologic: 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 |
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of memory | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | <input type="checkbox"/> loss of balance |

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

- | | | | |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion | <input type="checkbox"/> insomnia | |

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

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

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

- | | | | |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia | <input type="checkbox"/> blood clotting | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue | |

Patient Name: _____

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PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for Same Condition: I have not 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: _____ Was the treatment beneficial in resolving condition? 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 Unsure. Why? _____

Do you use any of the following? Heel lifts Arch supports Orthotics Cervical pillow Other _____

Allergies: Mark all that apply below. Write the TYPE of reaction you have immediately after allergy.

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> Medication allergies: | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> adhesive tape/ latex | <input type="checkbox"/> animals _____ | <input type="checkbox"/> bee stings | <input type="checkbox"/> dairy |
| <input type="checkbox"/> eggs | <input type="checkbox"/> feathers | <input type="checkbox"/> mold | <input type="checkbox"/> nuts |
| <input type="checkbox"/> peanuts | <input type="checkbox"/> perfumes | <input type="checkbox"/> pollen | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> soap/ detergent | <input type="checkbox"/> soy | <input type="checkbox"/> wheat/ gluten | <input type="checkbox"/> other _____ |

Current Medications, vitamins or herbs: List ANY/ALL medications you are CURRENTLY taking. Be Specific.

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

Childhood Illness(es): CHECK all past health conditions, then CIRCLE all CURRENT conditions.

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hayfever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

Adult Illness(es): CHECK all health past conditions, then 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"/> Alzheimer's | <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: |

Patient Name: _____

Date: _____

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

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 tonsilectomy
- carpal tunnel repair hemorrhoidectomy laminectomy other:
- coronary artery bypass hernia repair mastectomy

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:

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

- Alcohol: Never Social Consumption only Beer Liquor Wine ; _____ oz _____ glasses; Day Week Month
- Diet (please mark all that apply): High Fat High Fiber High Protein High Salt
- Low Calorie Low Carb Low Fiber Low Salt Low Sugar
- Education (please mark the highest level completed): Preschool Elementary Middle Junior High Votech
- In High School Did Not Finish High School High School Diploma Post High School Classes Assoc/Technical Degree
- In College College Degree In Graduate School Graduate Degree Doctorate Other: _____
- Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____ Have used drugs for _____
- Tobacco: Deny Tobacco Use Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
- Smoke; # _____ per Day Week Month Chew; # _____ cans per Day Week Year

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: _____

Patient Name: _____

Date: _____

Workers Compensation Injury / Auto / Personal Injury:

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

Carrier: _____ Policy # _____

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

Claim #: _____ Attorney: _____

I acknowledge that I have received Infinite Wellness Notice of Privacy Practices for protected health information.

I authorize payment of medical benefits to Infinite Wellness and authorize the release of any information necessary to process these claims. I assign any insurance benefits for treatment be paid directly to Infinite Wellness and any amounts received will be credited to my account. I understand health insurance and accident policies are an arrangement between the carrier and myself, therefore ultimately I am personally responsible for payment.

I hereby authorize the doctors to treat my condition as they deem appropriate through the use of Chiropractic care. I understand the risks and benefits of care and consent to treatment by Dr. Johnson and/or Dr. Curtis.

Patient Print Name: _____

Date: _____

Patient's Signature: _____

Date: _____

Parent or Guardian Authorizing Care: _____

Date: _____