FLORO CHIROPRACTIC • CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL HISTORY

Date: __________

Name: ____ Birth Date: ________________________ Sex: M / F

Address: ____City: ______________________State:______Zip:________________

Home Phone #: ______________________Cell Phone #:_______________________Business Phone #:________________________

Business Employer: ____________________________________ E-mail Address: _______________________________________

Occupation: ____ Preferred Contact #: ___________________________________

Name of Spouse: ______________________________________ Ages of Children: _____________________________________

Referred To This Office By: __________________________Primary Care Physician:___________________________________

Name/ Phone of Emergency Contact: ____ Relationship: _________________

Who is Responsible for your bill, you and ❑ Spouse ❑Worker's Comp ❑Auto Insurance ❑Other_____________

Please check type of care desired: ❑Temporary Relief ❑ Lasting Correction ❑ What the Doctor recommends

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today & how it started)____________________

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Mark an X on the diagram for areas of Discomfort, Pain or Numbness:

When did this condition start? ____

Has it ever occurred before? ❑No ❑Yes If yes, please explain (i.e. For how many years?)________________________________

____

Have you ever received any treatment for this condition? ❑Yes ❑No

If yes, where, when & what were your results?____

____

Has this problem been getting better, worse or staying the same? ____

Activities or movements that are painful to perform: ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying Down ❑ Other__________

How has this condition affected your life?

A. Home life: ____________________________________ C. Recreational life:_____________________________________

B. Occupational life: ______________________________ D. Rest/Sleep life:______________________________________

Any Chiropractor consulted in the past? ❑Yes ❑No Name:_______________________________________

Date consulted:______________________________ For what problem:_____________________________________

(PLEASE COMPLETE REVERSE SIDE)

Drugs you now take: ❑Nerve Pills ❑Pain Killers ❑Muscle Relaxers ❑Blood Pressure Medicine ❑Insulin ❑Allergy Medicine

❑Anti-Depressants ❑Other: ____

List Vitamins ____

List all conditions for which you have been treated in the last 10 years:____

____

Any known allergies to food, drugs, environmental, etc.?____

____

GENERAL HEALTH HISTORY – Mark the conditions that apply to you.

Are you Pregnant? ❑Yes ❑No If yes, what is your due date?______________________

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Respiratory Problems	❑	❑	Sleeping Issues
❑	❑	Urinary Problems	❑	❑	Cancer of ______________	❑	❑	Digestive Problems
❑	❑	Migraines	❑	❑	Fatigue	❑	❑	Vision Problems
❑	❑	Easy Bruising	❑	❑	Depression	❑	❑	Prostate Problems
❑	❑	Shortness of Breathe	❑	❑	Sinus Infections	❑	❑	Thyroid Problems
❑	❑	Weight Loss or Weight Gain	❑	❑	Poor Circulation	❑	❑	Tension / Irritability
❑	❑	Allergies / Asthma	❑	❑	Fainting	❑	❑	Liver Disease
❑	❑	Hormonal Issues	❑	❑	___High or ___Low Blood Pressure	❑	❑	Chest Pains
❑	❑	Dizziness	❑	❑	Gall Bladder Trouble	❑	❑	Kidney Problems
❑	❑	Fibromyalgia	❑	❑	Stroke History	❑	❑	Heart Pacemaker
❑	❑	Diabetes	❑	❑	Ringing In Ears	❑	❑	Light Bothers Eyes
❑	❑	Blood Thinnner use	❑	❑	High Cholesterol	❑	❑	Heart Problems
❑	❑	Hands or Feet cold	❑	❑	Ear Problems	❑	❑	Other______________________
❑	❑	HIV Positive	❑	❑	Jaw Clicking / Grinding			______________________

Injuries/Surgeries:	Description (area involved / injured)	Treatment Received	Year (approximate)
Falls / Sports	________________	________________	________________
Head Injuries	________________	________________	________________
Other Injuries	________________	________________	________________
Hospitalization / Surgeries	________________	________________	________________
Dislocations / Broken Bones	________________	________________	________________
List All Past Auto Collisions	________________	________________	________________
List All Past Work Injuries	________________	________________	________________

FAMILY HISTORY

Father's Side: ❑Heart Disease ❑Cancer ❑Diabetes ❑Heavy Medication use ❑Arthritis ❑Other ______________________

Mother's Side: ❑Heart Disease ❑Cancer ❑Diabetes ❑Heavy Medication use ❑Arthritis ❑Other ______________________

Is there any other family history you want us to know?____

SOCIAL HISTORY

EXERCISE	SLEEP	WORK ACTIVITY	DIET	HABITS	
❑None	❑8+ Hours	❑Sitting	❑High Protein	❑Smoking	Packs/Day______________
❑1-3x/Week	❑6-8 Hours	❑Standing	❑High Salt Intake	❑Tobacco	Amount________________
❑3-5x/Week	❑Less than 6 Hrs.	❑Light Labor	❑Low Carbohydrate	❑Alcohol	Drinks/Week_____________
❑5-7x/Week		❑Heavy Labor	❑Low Sugar	❑Coffee/Caffeine	Cups/Day_______________
List physical activities you participate in			❑Low Salt	❑High Stress Level	Reason________________
______________________________			❑Dieting	❑Soft Drinks/Cola	Cans/Day_______________
______________________________			❑Vegetarian	❑Water	Glasses/Day_____________
				❑Vitamin Detox	Times Yearly_____________