Park Ridge Chiropractic Centre

Dear Patient: This information is condsidered confidential. We need this information because your answers will help us to determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case... In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Confidential patient health record

Case # _____ Date _____

Name _____ (FIRST M. LAST) Home Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Sex _____ Age _____ Birth Date _____ Marital Status: Single _____ Married _____

Widow(er) _____ Divorced _____ How many children _____ Ages _____

Occupation _____ Employer _____

Address _____ Office Phone ( ) _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone ( ) _____

Patient's Nearest Relative _____ Phone ( ) _____

Referred by _____ If insurance claim, name of company _____

Present family doctor _____ Address _____

Who is responsible for your account _____

Describe major health complaint _____

When did it begin _____ What caused it _____

What makes it better _____

What makes it worse _____

Is it getting worse _____ Does it interfere with: work - sleep - Daily Routine - Other (Explain) _____

List doctors consulted for this condition:

Date _____ Name _____ Specialty _____ Address _____

Diagnosis/Treatment _____ Results _____

Date _____ Name _____ Specialty _____ Address _____

Diagnosis/Treatment _____ Results _____

Date _____ Name _____ Specialty _____ Address _____

Diagnosis/Treatment _____ Results _____

X-Rays or Special Tests _____ Dates _____

List other complaints:

1. _____ For how long _____
2. _____ For how long _____
3. _____ For how long _____
4. _____ For how long _____
5. _____ For how long _____

Doctors, treatment and remarks for above _____

What surgery have you had?

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Remarks _____

List serious accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
Remarks _____

List fractures:

What _____ When _____
What _____ When _____
Remarks _____

List conditions previously treated for:

What _____ When _____
What _____ When _____
What _____ When _____
Remarks _____

List medications and/or diet supplements you take:

What _____ Frequency _____ Doctor _____
What _____ Frequency _____ Doctor _____
What _____ Frequency _____ Doctor _____
What _____ Frequency _____ Doctor _____
What _____ Frequency _____ Doctor _____
Remarks _____

Family Health Information:	Age	Deceased	Health Problems or Cause of Death.
Father			
Mother			
Brothers:			
Sisters:			

Dates of Last: Physical examination _____ By Doctor _____
Results _____
Chest X-Rays _____ Spinal X-Rays _____ Dental X-Rays _____ Other X-Rays _____
Blood test _____ Urine Test _____ Other tests _____
Health Habits: How much? Day/Week
Tea, coffee _____ Liquor _____ Tobacco _____ Hours sleep _____
Exercise _____ Type _____ Special Diets: _____
Do you wear: Heel Lifts _____ Sole Lifts _____ Arch Supports _____ Other _____

Check any of the following diseases you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Veneral disease
- ☐ Whooping cough
- ☐ Chorea
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Mental disorder
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Phnemonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke

Circle current conditions . . . Check former conditions:

General symptoms
- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convolusions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Loss of weight
- ☐ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees or feet
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion

Eyes, ears, nose and throat
- ☐ Failing vision
- ☐ Near sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Eye inflamation
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Hay fever
- ☐ Allergies
- ☐ Asthma
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands

Skin
- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruises easily
- ☐ Dryness
- ☐ Boils
- ☐ Rashes
- ☐ Sensitive skin
- ☐ Hives or allergy

Respiratory
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Wheezing

Cardio-vascular
- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Varicose veins

Muscle and joint
- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Pain between shoulders
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Arthritis
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

Genitourinary
- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostrate trouble
- ☐ Bladder trouble
- ☐ Discolored urine

Gastrointestinal
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Bloody stool
- ☐ Colon trouble
- ☐ Hemmorrhoids (Piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble

Female
- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back ache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Congested breast
- ☐ Breast Pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office 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 the Doctor's Office will be credited to my account on 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS # _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour _____ AM _____ PM Location _____

How Did Accident Occur? ☐ Auto Collision ☐ On-the-job injury ☐ Other _____

If Not An Auto Collision, Please Describe The Circumstances _____

_____

_____

Did You Report the Injury to your Foreman or Employer? ☐ YES ☐ NO

Did He (They) Recommend Care at Our Office? ☐ YES ☐ NO

If Auto Accident, Were You Driver ☐ Passenger ☐ Pedestrian ☐

If Auto Collision Were You Struck From Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto Was Parked ☐

Did Your Car Strike The Other (s) Involved? ☐ YES ☐NO; Or Did The Other Car Strike Yours? ☐ YES ☐ NO ☐ Undetermined

As a Result of the Accident, Were Traffic Citations Issued to You? ☐ YES ☐ NO; To the Driver of the Other Car ☐ YES ☐NO;

To the Driver of Your Car ☐ YES ☐ NO

List the Extent of the Injuries as You Know Them _____

_____

_____

Did You Require Post-Accident Hospitalization? ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

Have You Lost Any Days of Work? _____ Dates: _____

Insurance Companies Involved:

My Company _____

Company of Person Responsible for Injuries _____

Have You Been Contacted by an Insurance Adjuster or Company Representative Regarding this Claim ☐ YES ☐ NO

Do You Have an Attorney that Has Advised You in This Case? ☐ YES ☐NO

Attorney's Name _____ Address _____ Telephone _____