



CONFIDENTIAL PATIENT HEALTH RECORD

DATE: ___/___/___

Personal History

First: _____ Middle: _____ Last: _____ Gender: Male / Female
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ County: _____ Country: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____ Birth Date: ___/___/___ Age: _____
Email Address: _____

Employer

Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (____) _____ - _____ Type of Work: _____

Circle One: Divorced Married Single Separated Widowed

Spouses Name: _____ Spouses Employer: _____
Spouses Occupation: _____ Work Phone# : _____
Ages of Children: _____

How were you referred to our office? _____

Emergency Contact

Name: _____ Phone Number: (____) _____ - _____
Address: _____
Relationship: _____

Who Is Responsible For Your Bill?

Self Health Insurance Work. Comp Auto Ins. Medicare Other (be specific): _____
Insurance Carrier: _____ ID #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: _____ - _____ - _____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N= Numbness
P=Pins & Needles S=Stabbing

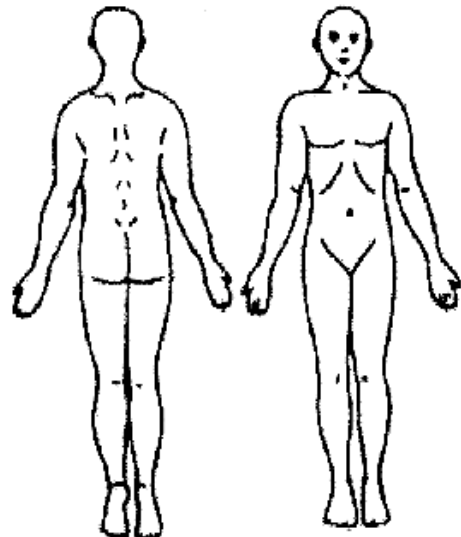
PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

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When did this complaint/condition begin? _____
Has it ever occurred before? Yes No
When? _____
Is the condition: Auto Related Work Related
 No Injury Other
Explain: _____

Does your pain radiate? Yes No
If yes, describe: _____

Have you lost time from work? Yes No



Have you seen other doctors for this condition? Yes No If yes, Who? (Name) _____

Location of Office: _____ Type of Treatment: _____

Were you satisfied with the results of your treatment? Yes No Explain: _____

Are you currently taking any prescription medications? Yes No If yes, please mark or list below (be specific).

Allergy Medication Anti-Depressants Blood Pressure Medication Insulin Muscle Relaxers
 Nerve Pills Pain Killers Other (please be specific): _____

Do you wear any of the following? No Heel Lifts Innersoles Arch Supports Orthotics

What is your goal for care at our office? What would you like to be able to do better and/or easier than you are doing right now?

Please Specify the Effect of your Current Condition on the following Daily Activities:

- Bending: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Care for Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: 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
- Ext Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Feeding Yourself: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- 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
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lifting (Generalized): No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Daily Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Reading/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
- Sexual Activities: 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
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static 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
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Please Specify the Effect of your Current Condition on your Recreational Activities:

(Please list Activity Below)

- _____ 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

REVIEW OF SYSTEMS--Below is a list of diseases 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.

– Please fill out all of the sections, even if “DENY”.

Constitutional (Pertaining to the Body as a Whole): Deny Any Constitutional Issue (s)

- Chills Daytime Somnolence (Drowsiness) Fatigue Fever Night Sweats
 Weight Gain Weight Loss

Eyes/Vision: Deny Any Eyes/Vision Issue (s)

- Blindness Blurred Vision Cataracts Change in vision Double Vision
 Eye Pain Field Cuts (visual field defect) Glaucoma Itching (around the eyes) Photophobia
 Tearing Wears Glasses and/or Contact lenses

Ears, Nose and Throat: Deny Any Ears, Nose and Throat Issue (s)

- Bleeding Dentures Difficulty Swallowing Discharge Dizziness
 Ear Drainage Ear Pain Fainting Headaches Frequent Sore Throats
 Head Injury (history of) Hearing Loss Hoarseness Loss of Smell Nasal Congestion
 Nose bleeds (frequent) Post Nasal Drip Rhinorrhea (Runny nose) Sinus Infections Snoring
 Tinnitus (Ringing in Ears) TMJ problems

Respiration: Deny Any Respiratory Issue (s)

- Asthma Cough Coughing up blood Shortness of Breath Sputum Production Wheezing

Cardiovascular: Deny Any Cardiovascular Issue (s)

- Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur
 Heart Problems High Blood Pressure Low Blood Pressure Orthopnea (difficulty breathing while lying down)
 Palpitations (irregular or forceful beating of the heart) Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)
 Shortness of Breath with Exertion or Exercise Swelling of Legs Ulcers Varicose Veins

Gastrointestinal: Deny Any Gastrointestinal Issue (s)

- Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea
 Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin)
 Nausea Rectal Bleeding Abnormal Stool Caliber (quality) Abnormal Stool Color
 Abnormal Stool Consistency Vomiting Vomiting Blood

Female: Deny Any Female Issue (s)

- Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination
 Hormone Therapy Irregular Menstruation Pregnancy Urine Retention Vaginal Bleeding Vaginal Discharge

Male: Deny Any Male Issue (s)

- Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Problems
 Urine Retention

Endocrine: Deny Any Endocrine Issue (s)

- Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst
 Frequent Urination Goiter Hair Loss Heat Intolerance Unusual Hair Growth
 Voice Changes

Skin: Deny Any Skin Issue (s)

- Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss Hives Itching
 Paresthesia (numbness, prickling, or tingling) Rash History of Skin Disorders Skin Lesions/Ulcers Varicosities

Nervous System: Deny Any Nervous System Issue (s)

- Dizziness Facial Weakness Headaches Limb Weakness Loss of Consciousness
 Loss of Memory Numbness Seizures Sleep Disturbance Slurred Speech
 Stress Strokes Tremors Loss of Balance

Psychologic: Deny Any Psychologic Issue (s)

- Anhedonia (inability to experience joy or enjoy life) Anxiety Appetite Changes Behavioral Change(s)
 Bipolar Disorder Confusion Convulsions Depression Insomnia Memory Loss
 Mood Change(s)

Allergy: I... Deny Any Allergy Issue (s)

Anaphylaxis (history of) Food Intolerance Itching Nasal Congestion Sneezing Rash

Hematology: I... Deny Any Hematologic Issue (s)

Anemia Bleeding Blood Clotting Blood Transfusion(s) Bruises easily Fatigue Lymph Node Swelling

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

Childhood Illness: Deny Any Childhood Illness(es)

ADD Allergies/Hayfever Asthma Atopic Dermatitis (Eczema) Bedwetting
 Cerebral Palsy Chicken Pox Depression Diabetes Ear Infections
 Fetal Drug Exposure Food Allergies Headaches Hepatitis HIV
 Measles Mumps Rash Scoliosis Seizure Disorder
 Sickle Cell Anemia Spina Bifida Other (please describe): _____

Adult Illness: Deny Any Adult Illness(es)

Alzheimers Anemia Arthritis Asthma Cancer
 Chicken Pox Crohn's/Colitis CRPS (RSD) CVA (stroke) Cystic Kidney Disease
 Depression Diabetes (Insulin) Diabetes (Non insulin) Ear Infections (frequent) Emphysema
 Eye Problems Fibromyalgia Heart Disease Hepatitis HIV
 Hypertension Influenzal Pneumonia Liver Disease Lung Disease Lupus Erythema (discoid)
 Lupus Erythema (systemic) Multiple Sclerosis Parkinson's Disease Pleurisy Pneumonia
 Psychiatric Problems Scoliosis Seizure Disorder Shingles STD's (unspecified)
 Suicide Attempt(s) Thyroid Problems Vertigo
 Past history of similar symptoms to your current condition Other Illness (please be specific): _____

Surgeries: Deny Any Surgery(ies)

Angioplasty Appendectomy Caesarian Section Cardiac Catheterization Carpal Tunnel Repair
 Coronary Artery Bypass Cosmetic D & C Dental Surgery Gallbladder
 Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction Joint Replacement
 Laminectomy Mastectomy Pacemaker Insertion Rotator Cuff Spinal Fusion
 Tonsilectomy Other (please be specific): _____

Ob/Gyn: Deny Any Ob/Gyn Issue(s)

Never been pregnant Have been pregnant in the past Currently pregnant (wks / mths)
_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____ Date of Last Menses ____/____/____

My menses is Regular Irregular I am currently in: Metaphase Menopause

Injuries: Deny Any Injury(ies)

Back Injury Broken Bones Severe Fall Fracture Disability
 Head Injury Industrial Accident Joint Injury Severe Laceration Motor Vehicle Accident
 Mild/Moderate Soft Tissue Injury Severe Soft Tissue Injury

Immunizations: Deny Any Immunization(s)

DTaP(diphtheria, tetanus, and pertussis) Flu Hepatitis A Hepatitis B Hepatitis C
 Influenza IPV (Polio) MMR (measles, mumps, and rubella) Pneumococcal
 PPD (Mantoux Test-TB) Small Pox TB Varivax (chicken pox) Whooping Cough (Pertussis)

Non-Drug Allergies: Deny Any Non-Drug Allergy(ies)

Animals Dairy Eggs Food Coloring Mold Pollen Wheat

Other (please be specific): _____

Type of Reaction: Swelling Anaphylaxis GI Disturbance Headache Joint Pain Rash Shortness of Breath

Other: _____

FAMILY HISTORY

Condition (Please be specific)

- General Family** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Father** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Mother** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Paternal Grandfather** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Paternal Grandmother** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Maternal Grandfather** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Maternal Grandmother** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Son (s)** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Daughter (s)** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Brother (s)** Alive Deceased Normally Developed No Significant Disease Has/Had: _____
- Sister (s)** Alive Deceased Normally Developed No Significant Disease Has/Had: _____

SOCIAL HISTORY

Alcohol: Never Social Consumption only Beer Liquor Wine ;
_____ oz _____ glasses; Day Week Month

Diet (Please mark all that apply): No Specific Diet High Fat High Fiber High Protein High Salt
 Low Calorie Low Carb Low Fiber Low Sugar Low Salt

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

Please list any other conditions you feel we should know about – even if unrelated:

*-Keeping us well-informed about your health helps us to provide you with the best care possible.-
Thank you for taking the time to complete this form to the best of your ability!*