

Confidential Patient Health Record

Date: ___/___/___

Personal History

Name: _____ Birth Date: ___/___/___ Age: ___ Gender: M/F
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____ State: _____ Email Address: _____

Employer

Business Name: _____ Occupation/Job Title: _____
Business Phone: (____) _____ - _____ Type of Work: _____
Referred to this Office by? _____
How did you hear about us? _____

Circle One: Divorced / Married / Single / Separated / Widowed

Spouses Name: _____ Spouse's Social Security #: _____ - _____ - _____
Spouses Employer/Type of Work: _____ Business Phone: _____
Name and Ages of Children: _____

Emergency Contact

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

Who Is Responsible For Your Bill?

Self Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____

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 O=Other

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 Work Related
 No Injury Other

Explain: _____

Date of Accident: _____

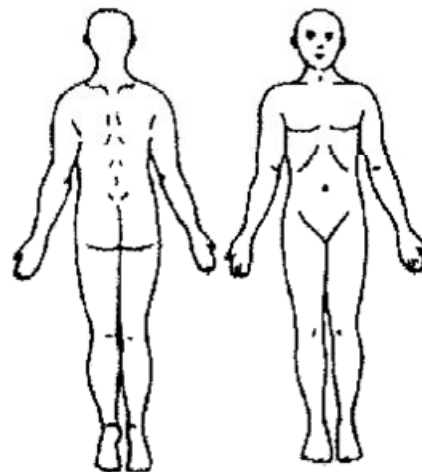
Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work Related:

Have you filed an injury report with your employer? Yes No

Claim #: _____



Have you seen other doctors for this condition? Yes No

Name Doctor/Location of Office: _____

Type of Treatment: _____

Are you currently taking any prescription medications? Yes No.

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

If yes, please mark or list below (be specific).

Insulin Muscle Relaxers

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics

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

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

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

- Fatigue Fever Night Sweats Weight Gain Weight Loss

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

- Blurred Vision Cataracts Change in vision Double Vision Eye Pain Glaucoma

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

- Bleeding Difficulty Swallowing Discharge Dizziness Ear Drainage Ear Infection(s)
 Ear Pain Fainting Headaches Head Injury Hearing Loss Hoarseness
 Sinus Infections Sore Throats (frequent) Tinnitus (Ringing in Ears) TMJ problems Loss of Smell

Respiration: I... Deny Any Respiratory Issue (s)

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

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

- Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur
 Heart Problems Difficulty breathing while lying down Palpitations
 Waking at night with shortness of breath Shortness of Breath with Exertion or Exercise Ulcers
 Swelling of Legs Varicose Veins

Gastrointestinal: I... 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 Color Vomiting

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

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

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

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

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

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

Nervous System: I... 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

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

Childhood Illness: I... Deny Any Childhood Illness (es)

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

Adult Illness: I... 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 Emphysema
 Eye Problems Fibromyalgia Heart Disease Hepatitis HIV
 Hypertension Influenzal Pneumonia Liver Disease Lung Disease Lupus Erythema (discoid)
 Lupus Erythema Multiple Sclerosis Parkinson's Disease Pleurisy Pneumonia
 Scoliosis Seizure Disorder Shingles STD's Thyroid Problems
 Past history of similar symptoms to your current condition Other Illness (please be specific): _____

Surgeries: I... Deny Any Surgery (ies)

- Angioplasty Appendectomy Caesarian Section Cardiac Catheterization Carpal Tunnel Repair
 Coronary Artery Bypass Cosmetic Gallbladder Hernia Repair Hysterectomy
 Joint Replacement Laminectomy Mastectomy Pacemaker Insertion Rotator Cuff
 Spinal Fusion Tonsillectomy Other (please be specific): _____

Injuries: I... Deny Any Injury (ies)

- Back Injury Broken Bones Severe Fall Fracture Disability Head Injury

Employment, ADL, and Recreation Information

Occupation/Job Title: _____ Work: _____ hrs / day or week
Description of Work: _____

Job Classification: Sedentary (<5lbs) Light (5-20lbs) Moderate (20-50lbs) Heavy (>50 lbs)

Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Lifting Postures: with Arms High Near from Knee Off Posture from Torso

Work Activity Postures: (hrs/day)

bending: _____ h/d climbing: _____ h/d kneeling: _____ h/d pulling: _____ h/d pushing: _____ h/d
 reaching: _____ h/d sitting: _____ h/d standing: _____ h/d twisting: _____ h/d walking: _____ h/d

Repetitive Activities: (hrs/day)

assembly/fine manipulation: _____ h/d computer use/typing: _____ h/d grasping: _____ h/d
 hand tool use: _____ h/d operation of machinery controls: _____ h/d phone use: _____ h/d

Condition's Effect On Job Performance: **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited ability)
Mod/Sev Limited Duty **Sev** No Limited Duty **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
Care –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
Extended Computer Use: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
Feeding: **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: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
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
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

Recreational Activity: Effects of Current Condition on Performance

_____ **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

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 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 any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's
Signature of authorizing care: _____ Date: _____