**CONFIDENTIAL PATIENT HEALTH RECORD** **DATE:**__________________________

## PERSONAL HISTORY

Name:_____________________________________________
Home Phone:____________________Cell Phone:_________________
Address:______________________________________________
City:________________________St.___________Zip_________
Birth Date:____________________ Age:________________ Sex: M or F
Marital Status:_____________________________
Business Employer:_______________________________________
Type of Work:_______________________________________
Business Phone:__________________________
Business Address:___________________________________________________
Name of Spouse:__________________________
Spouse's Employer:______________________________________________
Business Address:_______________________________________________
Business Phone:______________________________
Referred to this office by:_____________________________________________________
Name and Number of Emergency
Contact:_______________________________________________Relationship:___________________________

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## CURRENT HEALTH CONDITION

What brings you into our office today?____________________________________________________________
Other Doctors seen for this Condition: Yes or No
If yes, Who?________________________________________________
Type of
Treatment:_________________________________________Results:_____________________________________
When did this Condition Begin?___________________________________________________________________
Has This Condition Occurred Before? Yes or No
Is Condition: (circle one) Job Related; Auto Accident; Home Injury; Fall;
Other:_________________________
Date of Accident:____________________________________________Time of
Accident:_______________________________
Drugs you now take: (circle one) Nerve pills; Pain Killers/Muscle Relaxers; Blood Pressure Medicine;
Insulin; Other drugs not listed:_________________________________________________________________
Do you suffer from any other condition than that which you are now consulting us?
_____________________________________________________________________________________________

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## PAST HEALTH HISTORY

Please Circle and Describe:
Major Surgery: Appendectomy; Tonsillectomy: Gall Bladder; Hernia; Back Surgery; Broken Bones;
Other:_________________________________________________________________________________________
_____________________________________________________________________________________________
Major Accident or Falls:
_____________________________________________________________________________________________
Hospitalization (Other than above):
_____________________________________________________________________________________________
Previous Chiropractic Care: None_____
Previous Doctor's Name & Approximate Date of last visit:__________________________________________