CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL HISTORY

Name:_____ Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Birth Date:_____ Age:_____ Sex: __M __F
Social Security #:_____ Circle One: Single Married Widowed Divorced
Email Address:_____ May we add you to our email list? ___Yes ___No
Business Employer:_____ Business Phone:_____
Type of Work:_____ Names & Ages of Children:_____
Name of Spouse:_____ Spouse's Social Security #:_____
Spouse's Employer:_____ Business Phone:_____
Whom may we thank for referring you to our office?_____
Name and number of Emergency contact:_____
Who is responsible for Your Bill, You and ___Spouse ___Worker's Comp ___Auto Ins
Personal Health Insurance (Name):_____ HealthCard#:_____
Guarantor Date of Birth_____

CURRENT HEALTH CONDITION

Purpose of This Appointment:_____
Other Doctors Seen For This Condition: ___Yes ___No Who?_____
Type of Treatment:_____ Results:_____
When Did This Condition Begin?_____ Has it Occurred Before? ___Yes ___ No
Is Condition: ___Job Related ___Auto Accident ___Home Injury___Fall___Other:_____
Date of Accident:_____ Time of Accident:_____
Have You made a Report of Your Accident To your Employer: ___Yes ___No
Drugs You Now Take: ___Nerve Pills ___Pain Killers/Muscle Relaxers ___Blood Pressure
___Insulin ___Other:_____
Do You Wear A Shoe Lift? ___Yes ___No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?____
_____
Family Doctor:_____ Location:_____
Specialty Doctor: _____ Location:_____
Chiropractor:_____ Location:_____

PAST HEALTH HISTORY

Please Check And Describe:
Major Surgery/Operations: ___Appendectomy ___Tonsillectomy ___Gall Bladder ___Hernia
___Back Surgery ___Broken Bones ___Other:_____
Major Accidents or Falls:_____
_____
Hospitalization (Other Than Above):_____
_____
Previous Chiropractic Care: ___None ___ Doctor's Name & Approximate Date of Last Visit
_____

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of Chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

___Pneumonia
___Rheumatic Fever
___Polio
___Tuberculosis
___Whooping Cough
___Anemia
___Measles
___Mumps
___Small Pox
___Chicken Pox
___Diabetes
___Cancer
___Heart Disease
___Thyroid
___Influenza
___Pleurisy
___Arthritis
___Epilepsy
___Mental Disorders
___Lumbago
___Eczema

Do you use the following:
___Coffee
___Soda Pop
___Tea
___Alcohol
___Cigarettes
___White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
___Low Back Pain
___Pain Between Shoulders
___Neck Pain
___Arm Pain
___Walking Problems
___Difficult Chewing
___General Stiffness

GASTRO-INTESTINAL CODE
___Poor/Excessive Appetite
___Excessive Thirst
___Frequent Nausea
___Vomiting
___Diarrhea
___Constipation
___Hemorrhoids
___Liver Problems
___Gall Bladder Problems
___Gas/Bloating after meals
___Heartburn
___Black/Bloody Stool
___Colitis

GENITO-URINARY CODE
___Bladder Trouble
___Painful/Excessive Urine
___Discolored Urine

MALE/FEMALE CODE
___Menstrual Irregularity
___Menstrual Cramps
___Vaginal Pain/Infection
___Breast Pain/Lumps
___Prostate/Sexual Dysfunction
___Other_____
_____

NERVOUS SYSTEM CODE
___Nervousness
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Fainting
___Stress
___Cold/Tingling Extremities

GENERAL CODE
___Fatigue
___Allergies
___Loss of Sleep
___Fever
___Headaches
___Other_____
_____

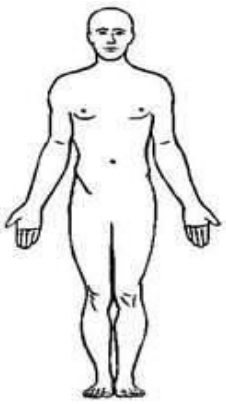
C-V-R CODE
___Chest Pain
___Short Breath
___Blood Pressure Prob
___Irregular Heartbeat
___Heart Problems
___Lung Congestion
___Varicose Veins
___Ankle Swelling
___Stroke

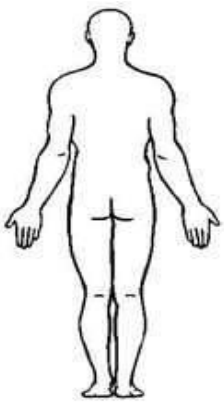
EENT CODE
___Vision Problems
___Dental Problems
___Sore Throat
___Ear Aches
___Hearing Difficulty
___Stuffed Nose

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols below. Please include all affected areas.

==== Numbness
xxxx Burning
oooo Pins/needles
/////// Stabbing Pain
++++ Dull Ache

Notes:_____
_____
_____
_____
_____





IF YOU ARE FEMALE:

I,_____ state that to the best of my knowledge I am not currently pregnant. I authorize Gerstenkorn Family Chiropractic, P.C., and whomever they may designate as doctors and assistants, to take the radiographs they determine to be necessary in my care and treatment. *In the interest of protecting your unborn child we ask that you inform our staff if you become pregnant during your care with Gerstenkorn Family Chiropractic, P.C..*

Please sign here:_____