

Confidential Patient Health Record

Date: _____ I.D. No. _____

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
Cell Phone #: _____ Email: _____
Social Security #: _____ Circle one: Married Single Widowed Divorced Separated
Business Employer: _____ Type of Work: _____
Business Phone: _____ Who referred you to this office: _____
Name of Spouse: _____ Spouse's Social Security #: _____
Spouse's Employer: _____ Business Phone: _____
Type of Work: _____ Names and Ages of Children _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who is Responsible for your bill: You and Spouse Workers' Comp Auto Insurance Health Insurance
Please Print Health Insurance Company: _____ Insurance ID #: _____

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 this condition 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 Insurance Company Yes No
Drugs you now take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Sleep Aids
 Insulin Other _____
Do you wear a shoe lift? Yes No Have you ever worn a spinal brace? Yes No
Do you suffer from any Condition other than that which you are now consulting us? _____

PAST HEALTH HISTORY

Please check and describe:
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
Major Accident or Falls: _____
Hospitalization (Other than Above): _____
Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit: _____

Below are a list 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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

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
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

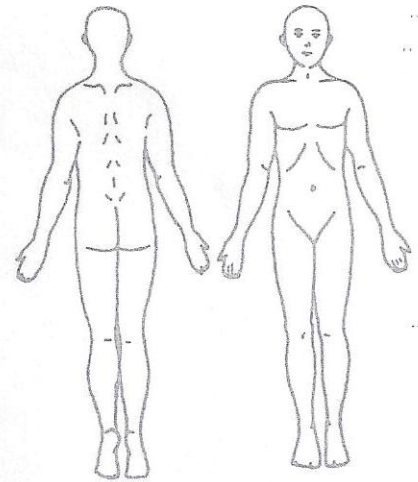
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief
Care

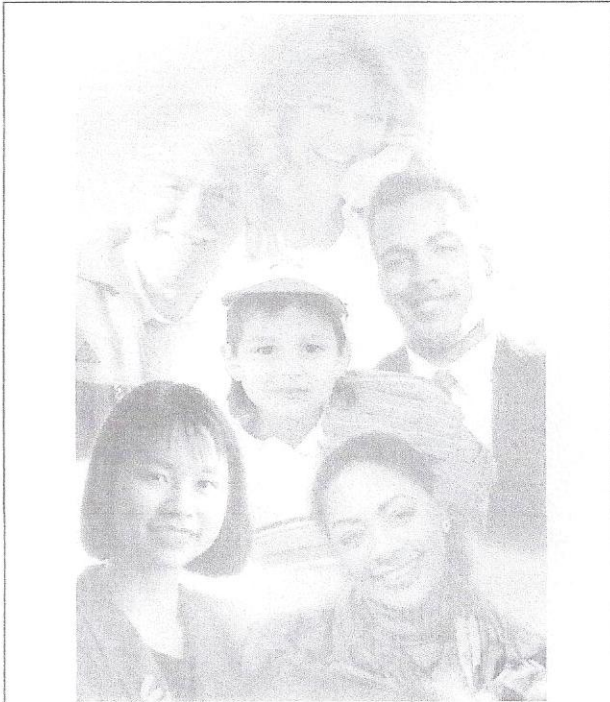
Corrective
Care

Check here if you want the Doctor to select the
type of care appropriate for your condition

Date

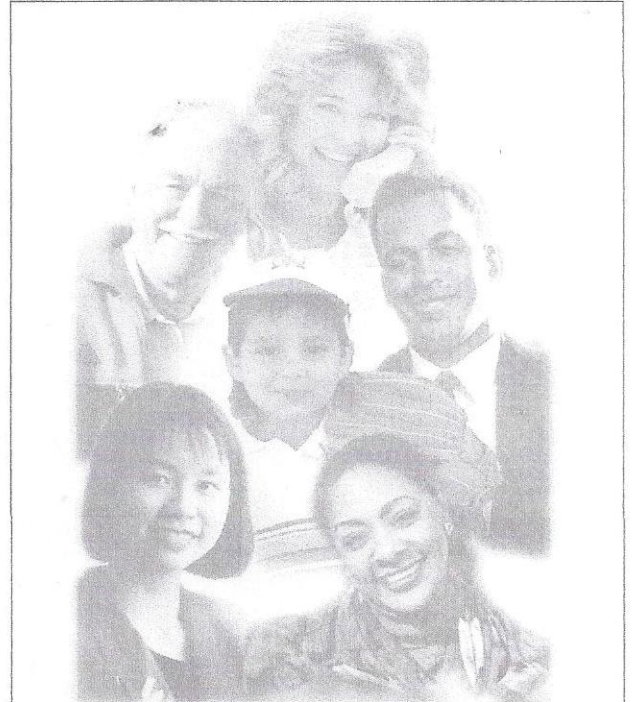
Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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 to 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 through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, is for examination and x-rays only. 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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Woodstock Chiropractic

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Terms of Acceptance

When a patient seeks Chiropractic care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal; that is the detection and correction of the Vertebral Subluxation Complex. It is important that each patient understand this goal and how it is to be attained.

Vertebral Subluxation Complex : A misalignment of one or more of the 24 movable segments in the spinal column, which causes alteration of nerve function and interference with the transmission of mental impulses; resulting in a lessening of the body's innate ability to express it's maximum health potential.

Health: A state of optimum physical, mental and emotional well-being, and not merely the absence of disease or infirmity.

Adjustment: The specific application of forces to facilitate the body's correction of the Vertebral Subluxation Complex.

We do not offer to diagnose or treat any disease or condition other than the Vertebral Subluxation Complex. However, if during the course of your care, we encounter unusual findings, we will inform you of such. If you desire advice, diagnosis or treatment, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the treatment prescribed by others. Our objective is to eliminate interference to your nervous system, allowing your body to function at it's maximum potential.

I, _____, have read and fully understand the above statements.

All questions regarding the Doctor's objectives pertaining to my care have been answered to my complete satisfaction. I therefore accept Chiropractic care on this basis.

Signature

Date