Confidential Patient Health Record

Name: ______________________

Address: ______________________

City: ______________________

State: __________ Zip: __________

Social Security #: ______________________

Driver's Lic.: ______________________

Employer: ______________________

Type of Work: ______________________

Referred to this Office by: ______________________

____

Emergency Contact: ______________________

Phone: ______________________

Relationship: ______________________

Today's Date: ______________________

Birth Date: __________ **Age:** __________

Sex: Male Female

Home Phone: ______________________

Work Phone: ______________________

Cell Phone: ______________________

E-Mail: ______________________

Spouse's Name: ______________________

Spouse's Date of Birth: ______________________

Spouse Employer: ______________________

Names and Ages of Children:

____

____

Primary Care Doctor: ______________________ Number: ______________________

Dentist: ______________________ Number: ______________________

Current Health Condition: ☐ **NEW PATIENT** ☐ **NEW CONDITION**

Chief Complaint: (Why are you here today?)

____

____

____

____

When did the condition begin? __________

Has it occurred before? ☐ Y ☐ N When: __________

Is the Cause: ☐ Auto Accident ☐ Work Injury ☐ Other Injury ☐ No Injury

Date/Time of Accident: ______________________

Pain Onset Date: ______________________

Do you have an injury report? ☐ Yes ☐ No

Do you have a claim number? ☐ Yes ☐ No

If Yes: ______________________

Other Information:

____

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____

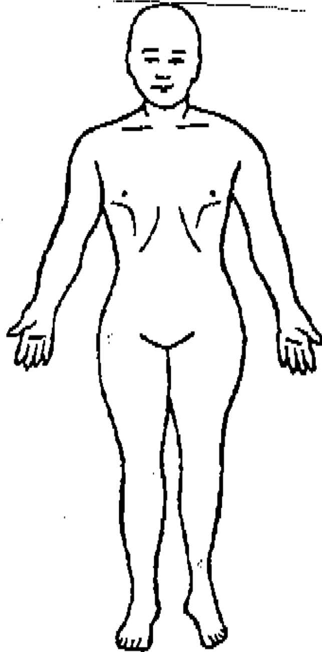
____

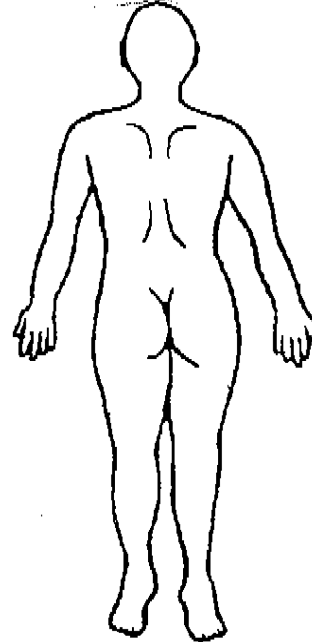
Total Body

Health Center, s.c.

Expect Something Better!

Please Indicate on the diagram any areas of pain/discomfort: ☐ I'm here for Wellness Care





Pain Scale: Rate your pain from 1 to 10, with 10 being the worst:

Area 1:	1	2	3	4	5	6	7	8	9	10
Area 2:	1	2	3	4	5	6	7	8	9	10
Area 3:	1	2	3	4	5	6	7	8	9	10

Daily Living, Work and Recreational Activities Impairments:
Rate as: **(N)** No Pain, **(P)** Painful, **(L)** Limited after 15 minutes, **(U)** Unable to perform for any length of time:

Standing____ Sitting_____ Walking_____ Kneeling_____ Stooping_____ Sit to Stand_____ Reaching_____

Climbing Stairs_____ Driving_____ Shopping_____ Vacuuming_____ Dishes_____ Cooking_____ Laundry____

Yard Work_____ Garbage_____ Lifting Groceries_____ Washing_____ Brushing Teeth/Hair_____ Dressing_____

Sleeping (8 Hours)_____ Concentration_____ Patience_____ Turning in Bed_____ Sexual Activities_____

Other Activities: ____

Past Injuries: Auto, Work, Sports or Other: ☐ None ☐ No Changes Since Last Visit

____

Other Doctors seen for this condition: ☐ NO ☐ YES Who? ______________________________

Type of Treatment: ______________________________ Results: ______________________________

Patient Name: ______________________ **Signature:** ______________________ **Date:** __________

Confidential Patient Health Record:

Current Health Status:

Exercise: ☐ Daily ☐ Frequent (3-5x/week) ☐ Occasional (1-2x/week) ☐ Need Help!

Weight: ☐ Ideal ☐ Slightly Overweight(10-25lbs) ☐ Very Overweight (25 lbs+)

Coffee/Soda ☐ Never ☐ Occasional (1-2/week) ☐ Often (3-7/week) ☐ Daily

Personal Health Goals, (What can we help you with?): ______________________________

____

Does your health status/condition affect your life in your ability in any of the following areas:

☐ Ability to work ☐ Ability to sleep ☐ Ability to walk ☐ Enjoy Hobbies ☐ Leisure
☐ Ability to walk ☐ Recreational Activities ☐ Ability to eat
☐ Household duties ☐ Other: ______________________________

Prescription and Over the Counter Drugs you now take: ☐ **No Changes Since Last Evaluation**

____
____
____

Do you wear heel lifts or arch supports, (orthotics)? ☐ **Yes** ☐ **NO** ______________________________

Review of Symptoms: Please fill out all sections, even if 'NONE': ☐ **No Changes Since Last Evaluation**

Social Hisory:
Alcohol: ☐ None ☐ YES: Number of drinks per week: ______________
Tobacco: ☐ Cigarettes ☐ Cigars Amount: ______________________________

Past Health History:

Childhood Illness: ☐ Allergies ☐ Asthma ☐ Chicken Pox ☐ Diabetes ☐ Food Allergies ☐ Headaches
☐ Measles ☐ Mumps ☐ Rash ☐ Seizure Disorder
☐ ADD ☐ Explain/Other: ______________________________

Adult Illness: ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Stroke ☐ Depression ☐ Diabetes
☐ Eye Problems ☐ Heart Disease ☐ Lung Disease ☐ Hypertension ☐ Psychiatric Problems
☐ Other: ______________________________

OB/GYN: ______________________________
Allergies: ☐ None ☐ Describe: ______________________________
Fatigue ☐ YES, Please Describe: ______________________________
☐ NONE
Eyes: ☐ YES, Please Describe: ______________________________
☐ NONE
Ear/Nose/Throat: ☐ Yes, Please Describe: ______________________________
☐ NONE
Respiration: ☐ Yes, Please Describe: ______________________________
☐ NONE
Heart Issues: ☐ Yes, Please Describe: ______________________________
☐ NONE
Digestion: ☐ Yes, Please Describe: ______________________________
☐ NONE

Female: ☐ Yes, Please Describe: ____________________
☐ NONE

Male: ☐ Yes, Please Describe: ____________________
☐ NONE

Endocrine: ☐ Yes, Please Describe: ____________________
☐ NONE

Skin: ☐ Yes, Please Describe: ____________________
☐ NONE

Nervous: ☐ Yes, Please Describe: ____________________
☐ NONE

Psychological: ☐ Yes, Please Describe: ____________________
☐ NONE

Blood: ☐ Yes, Please Describe: ____________________
☐ NONE

Family History: ☐ **No Changes Since Last Evaluation**

	Alive	Deceased	Cause / Condition / Comments:
Father	☐	☐	
Mother	☐	☐	
Paternal Grandfather	☐	☐	
Paternal Grandmother	☐	☐	
Maternal Grandfather	☐	☐	
Maternal Grandmother	☐	☐	
Brothers	☐	☐	
Sisters	☐	☐	
Children	☐	☐	

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 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/she deems appropriate. It is understood and agreed that 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:** ____________