wholebody solutions

nutrition • chiropractic • acupuncture • brain integration

Confidential Patient Health Record

***Today's Date*:____/____/_____**

How did you hear about us? ☐ **Family** _____ ☐ **Friend** _____ ☐ **Co-Worker** _____
☐ **Close to home/work** ☐ **Dr.** _____ ☐ **Internet** ☐ **Drove by** ☐ **Hospital** ☐ **Insurance Plan**

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Birth Date: ____ /____/_____ **Age:**_____ **Sex: Male / Female** **SSN:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____**)** _____-_____ **ext** _____ **Cell Phone: (**_____**)** _____-_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Preferred Method of Communication for Reminder (circle one): Email/ Phone/ Text

Race (Circle One): American Indian or Alaska Native/ Asian/ Black or African American/ White (Caucasian)/ Native Hawaiian or Pacific Islander/ Other/ I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino/ Not Hispanic or Latino/ I Decline to Answer

Emergency Contact

Last:_____ **First:**_____**Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____**)** _____-_____ **ext** _____ **Cell Phone: (**_____**)** _____-_____ **ext** ___

Work Phone: (_____**)** _____-_____ **ext** _____

Employment Information

Business Name: _____

Phone: (_____**)** _____-_____ **Fax #: (**_____**)** _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Patient Name: _____ Date:_____

Condition's Effect On Job Performance:

□ **Mild** Painful (Can do) □ **Mod** Painful (limited ability) □ **Mod/Sev** Limited Duty □ **Sev** No Limited Duty □ **Sev** (can't do limited duty)

Current Health Condition

Unwanted Condition (Why you are here today?):_____

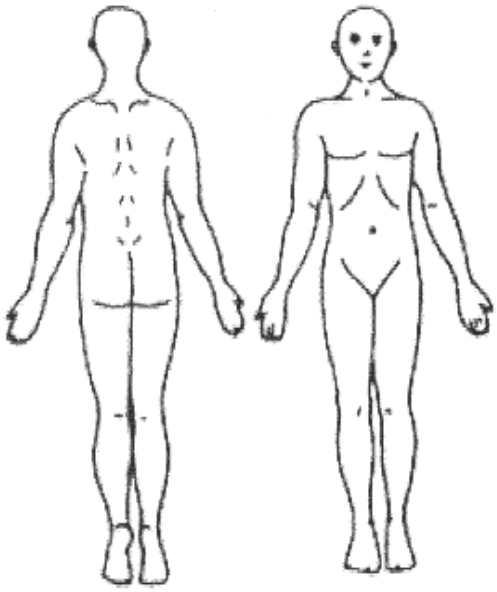
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? □ **Yes** □ **No. When?** _____

Is the Condition: □ **Auto Related** □ **Job Related** □ **Home Injury**

□ **Slip or Fall** □ **Lifting** □ **Slept Wrong** □ **Unknown Cause** □ **Other**

Date of Accident: _____**Time of Accident**: _____ **am /pm**
Condition/Pain STARTED on what Date: _____

Quality: □ **Burning** □ **Diffuse** □ **Dull/Aching** □ **Radiating**
□ **Sharp** □ **Shooting** □ **Stabbing** □ **Throbbing**
□ **Tightness** □ **Tingling** □ **Other**

Timing: ***Worse*:** □ **Morning** □ **Afternoon** □ **Night** □ **With Activity;**
□ **Constant** □ **Intermittent**

Context: ***Better with:*** □ **Warm Temp** □ **Cold Temp** □ **activity**
□ **bending** □ **applying cold** □ **applying heat**
□ **Massage** □ **movement** □ **OTC meds** □ **Rx meds** □ **rest**
□ **Stretching** □ **sitting** □ **standing** □ **twisting** □ **walking**

□ **Nothing helps**
Worse with: □ **Warm Temp** □ **Cold Temp** □ **Damp**
□ **bending** □ **applying cold** □ **applying heat**
□ **Massage** □ **movement** □ **OTC meds** □ **Rx meds** □ **rest**
□ **Stretching** □ **sitting** □ **standing** □ **twisting** □ **walking**

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Patient Name: _____ Date:_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ **chills**	☐ **fatigue**	☐ **night sweats**	☐ **weight loss**
☐ **daytime drowsiness**	☐ **fever**	☐ **weight gain**	

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **blindness**	☐ **change in vision**	☐ **field cuts**	☐ **photophobia**
☐ **blurred vision**	☐ **double vision**	☐ **glaucoma**	☐ **tearing**
☐ **cataracts**	☐ **eye pain**	☐ **itching**	☐ **wear glasses/contacts**

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **bleeding**	☐ **ear drainage**	☐ **hearing loss**	☐ **nosebleeds**	☐ **sore throat**
☐ **dentures**	☐ **ear pain**	☐ **history of head injury**	☐ **postnasal drip**	☐ **tinnitus (ringing in ears)**
☐ **difficulty swallowing**	☐ **fainting**	☐ **hoarseness**	☐ **rhinorrhea (runny nose)**	☐ **TMJ problems**
☐ **discharge**	☐ **frequent sore throats**	☐ **loss of sense of smell**	☐ **sinus infections**	
☐ **dizziness**	☐ **headaches**	☐ **nasal congestion**	☐ **snoring**	

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **asthma**	☐ **coughing up blood**	☐ **sputum production**
☐ **cough**	☐ **shortness of breath**	☐ **wheezing**

Smoking Status (circle one): Everyday Smoker/ Occasional Smoker/ Former Smoker/ Never Smoked

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **angina (chest pain or discomfort)**	☐ **high blood pressure**	☐ **shortness of breath with exertion or exercise**
☐ **chest pain**	☐ **low blood pressure**	☐ **swelling of legs**
☐ **claudication (leg pain/ache)**	☐ **orthopnea (difficulty breathing lying down)**	☐ **ulcers**
☐ **heart murmur**	☐ **palpitations**	☐ **varicose veins**
☐ **heart problems**	☐ **paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)**	

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **abdominal pain**	☐ **diarrhea**	☐ **indigestion**	☐ **abnormal stool caliber**	☐ **vomiting blood**
☐ **belching**	☐ **difficulty swallowing**	☐ **jaundice**	☐ **abnormal stool color**	
☐ **black - tarry stools**	☐ **heartburn**	☐ **nausea**	☐ **abnormal stool consistency**	
☐ **constipation**	☐ **hemorrhoids**	☐ **rectal bleeding**	☐ **vomiting**	

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ **birth control**	☐ **cramps**	☐ **irregular menstruation**	☐ **vaginal bleeding**
☐ **breast lumps/pain**	☐ **frequent urination**	☐ **pregnancy**	☐ **vaginal discharge**
☐ **burning urination**	☐ **hormone therapy**	☐ **urine retention**	

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **burning urination**	☐ **frequent urination**	☐ **prostate problems**
☐ **erectile dysfunction**	☐ **hesitancy/ dribbling**	☐ **urine retention**

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ **cold intolerance**	☐ **excessive hunger**	☐ **goiter**	☐ **unusual hair growth**
☐ **diabetes**	☐ **excessive thirst**	☐ **hair loss**	☐ **voice changes**

Patient Name: _____ Date:_____

□ excessive appetite □ abnormal frequency of urination □ heat intolerance

Skin: □ **I DENY having any of the symptoms or problems listed below.**

□ changes in nail texture □ hair loss □ itching □ skin lesions / ulcers
□ changes in skin color □ hives □ paresthesias □ varicosities
□ hair growth □ history of skin disorders □ rash

Nervous System: □ **I DENY having any of the symptoms or problems listed below.**

□ dizziness □ limb weakness □ numbness □ slurred speech □ tremor
□ facial weakness □ loss of consciousness □ seizures □ stress □ unsteadiness of gait/ loss of balance
□ headache □ loss of memory □ sleep disturbance □ strokes

Psychologic: □ **I DENY having any of the symptoms or problems listed below.**

□ anhedonia □ behavioral change □ convulsions □ memory loss
□ anxiety □ bi-polar disorder □ depression □ mood change
□ loss or change in appetite □ confusion □ insomnia

Allergy: □ **I DENY having any of the symptoms or problems listed below.**

□ anaphalaxis □ itching □ chronic nasal congestion □ sneezing
□ food intolerance □ acute nasal congestion □ rash

Hematologic: □ **I DENY having any of the symptoms or problems listed below.**

□ anemia □ blood clotting □ bruising easily □ lymph node swelling
□ bleeding □ blood transfusion □ fatigue

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

Previous Care for this Same Condition:
□ **I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____
Type of Treatment: _____Was the treatment beneficial in resolving condition? □ Yes □ No

Explain: _____

Previous Chiropractic Care: □ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Medication (s) Allergies: **List ANY/ALL medications you are allergic to**

Patient Name: _____ Date:_____

☐ **ADD**	☐ **cystic kidney disease**	☐ **hypertension**	☐ **psychiatric problems**
☐ **alzheimers**	☐ **depression**	☐ **influenzal pneumonia**	☐ **scoliosis**
☐ **anemia**	☐ **diabetes (insulin dep)**	☐ **liver disease**	☐ **seizures**
☐ **arthritis**	☐ **diabetes (non insulin)**	☐ **lung disease**	☐ **shingles**
☐ **asthma**	☐ **eczema**	☐ **lupus erythema (discoid)**	☐ **past history of similar symptoms**
☐ **cancer**	☐ **emphysema**	☐ **lupus erythema (systemic)**	☐ **STD's (unspecified)**
☐ **cerebral palsy**	☐ **eye problems**	☐ **multiple sclerosis**	☐ **suicide attempt(s)**
☐ **chicken pox**	☐ **fibromyalgia**	☐ **parkinson's disease**	☐ **thyroid problems**
☐ **crohn's/colitis**	☐ **heart disease**	☐ **unspecified pleural effusion**	☐ **vertigo**
☐ **CRPS (RSD)**	☐ **hepatitis**	☐ **pneumonia**	☐ **other:**
☐ **CVA (stroke)**	☐ **HIV**	☐ **psoriasis**	☐ **allergies/hayfever**
☐ **bedwetting**	☐ **ear infections**	☐ **fetal drug exposure**	☐ **food allergies (list below)**
☐ **headaches**	☐ **measles**	☐ **mumps**	☐ **rash**
☐ **sickle cell**	☐ **spina bifida**		

Illness(es): **LIST all health conditions. CIRCLE all conditions.**

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ **angioplasty**	☐ **cosmetic**	☐ **hysterectomy**	☐ **pacemaker insertion**
☐ **appendectomy**	☐ **D & C**	☐ **joint reconstruction**	☐ **rotator cuff**
☐ **caesarian section**	☐ **dental surgery**	☐ **joint replacement**	☐ **spinal fusion**
☐ **cardiac catheterization**	☐ **gall bladder**	☐ **knee repair**	☐ **tonsilectomy**
☐ **carpal tunnel repair**	☐ **hemorrhoidectomy**	☐ **laminectomy**	☐ **other:**
☐ **coronary artery bypass**	☐ **hernia repair**	☐ **mastectomy**	

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ **back injury**	☐ **head injury (loss of consciousness)**	☐ **motor vehicle accident**
☐ **broken bones**	☐ **head injury (no loss of consciousness)**	☐ **soft tissue injury (mild)**
☐ **disability (ies)**	☐ **industrial accident**	☐ **soft tissue injury (moderate)**
☐ **fall (severe)**	☐ **joint injury**	☐ **soft tissue injury (severe)**
☐ **fracture**	☐ **laceration (severe)**	☐ **other:**

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
father	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
mother	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
paternal grandfather	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
paternal grandmother	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
maternal grandfather	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
maternal grandmother	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
son (s)	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____
daughter(s)	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:** _____
brother(s)	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:** _____
sister(s)	☐ **alive**	☐ **deceased**	☐ **normally developed**	☐ **no significant disease**	☐ **has/had:**_____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____