

# Advanced Chiropractic Nutrition Center, P.A.

440 Third St., Suite A Neptune Beach, Florida 32266  
(904) 249-5999, (904) 249-1768 (fax)

## Confidential Patient Health Record

### Personal Information:

Title:  Mr.  Ms.  Mrs.  Dr.  Rev

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male/Female

Marital Status:  Single  Married  Widowed  Divorced  Separated

Spouse Name: \_\_\_\_\_ Children's Names/Ages: \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Hrs/wk \_\_\_\_\_

Job Duties % of time: Sitting: \_\_ Standing \_\_ Walking \_\_ Light Labor \_\_ Heavy Labor \_\_

How did you hear about our office? Friend\_ Referral\_ Internet\_ Location\_ Insurance Co.\_  
other? \_\_\_\_\_

### Emergency Contact:

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_

Contact number: \_\_\_\_\_

Relationship to patient:  Spouse  Relative  Friend  other \_\_\_\_\_

### Insurance Information:

Insurance Carrier: \_\_\_\_\_ Pol Holder Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holders Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Current Health Condition:

1. What is chief complaint (what brought you into the office today)?  
\_\_\_\_\_
2. When did the discomfort start? \_\_\_\_\_
3. Was the onset sudden or gradual? \_\_\_\_\_
4. Is the condition  Auto Related  Job Related  Home Injury  Slip or Fall  Lifting  
 Slept wrong  Unknown Cause  Other Explain: \_\_\_\_\_

5. Since the problem began have the symptoms been getting worse or have they been relatively unchanged? \_\_\_\_\_
6. What aggravates the discomfort? \_\_\_\_\_
7. What relieves the discomfort? \_\_\_\_\_
8. Does it radiate into the arms, hands, buttocks, legs or feet? If yes, explain  
\_\_\_\_\_
9. How would describe your discomfort? (circle all that apply) aching, burning, deep, dull, numb, sharp, stabbing, throbbing, tight, tingling. Other? \_\_\_\_\_
10. What is the severity? 1-10 with 10 being the worst? \_\_\_\_\_
11. The discomfort is worse? \_morning \_afternoon, \_ evening \_
12. Is the discomfort \_constant \_ intermittent \_varies
13. Have you had any prior interventions or treatments? \_\_\_\_\_
14. List any medications you are taking for this condition? \_\_\_\_\_
15. Are the medications helping? Y or N
16. Do you suffer with any other condition that you would like us to look at? Y or N Explain:  
\_\_\_\_\_  
\_\_\_\_\_
17. Have you had any specialized tests, i.e. MRI or CT scan? Y or N \_\_\_\_\_
18. Do you have any herniated discs or bulging discs? Y or N \_\_\_\_\_
19. Do you have current x-rays? Y or N. If yes, where? \_\_\_\_\_
20. Difficulty:  Sitting  Lying  Walking  Standing  Rolling Over  Getting Up/Down  Sleeping

**Past Health History:**

Have you seen other doctors for this condition?  Y or  N. If yes, who? \_\_\_\_\_  
 Type of treatment: \_\_\_\_\_ Were you satisfied with the results of your treatment?  Y or  N if no explain, \_\_\_\_\_  
 Previous Chiropractic Care:  I have not previously seen a Chiropractor or fill in below.  
 Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of your last visit? \_\_\_\_\_ Were you satisfied with your care? \_\_\_\_\_

**Accidents or Injuries:**

No prior accidents/Injuries or fill out below:  
 What type of accident did you have?  Auto  Slip/Fall  Work  Motorcycle  Other \_\_\_\_\_  
 When was the injury? \_\_\_\_\_  
 What injuries did you sustain? \_\_\_\_\_  
 Have you ever had a litigated claim following an accident? Y or N.  
 Did you receive a settlement? Y or N  
 Have you ever been rated with a permanent impairment rating following an accident? Y  or N  %

**Surgeries:**  No previous surgeries or fill in below.  
 Appendectomy  Back  C-Section  Dental  D&C  Gallbladder  Heart  Hernia repair  
 Hysterectomy  joint replacement or repair ( L or R) -knee, shoulder, hip or other \_\_\_\_\_  
 Laminectomy  Mastectomy  Neck  Rotator cuff  Skin Cancer  Stomach  Spinal Fusion  
 Vasectomy  Other Cancer  Other \_\_\_\_\_

**Hospitalizations:**  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_

**Current Medication:** List any and all medication.  
\_\_\_\_\_ Dosage: \_\_\_\_\_  
\_\_\_\_\_ Dosage: \_\_\_\_\_

**Supplements:** List all vitamins/ minerals  
\_\_\_\_\_ Dosage \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_

**Females only:** Ob/Gyn  
Females: Any possibility of Pregnancy? Y or N (initials) \_\_\_\_\_  
I  currently have menses.  currently do not have menses.  
My menses are  regular  irregular  
Date of last menses? \_\_\_\_\_

**Allergies:** Do you have any drug or food allergies?  N  Y.  
If yes, explain \_\_\_\_\_

**Family History:** List any family history of disease or illness  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**  
Cigarette/Cigar  none  Previous  Current #Packs/day \_\_\_\_\_ #Yrs. \_\_\_\_\_  
Coffee #Cups/day \_\_\_\_\_ Reg or Decaf  
Tea #cups/day \_\_\_\_\_  
Alcohol  do not drink  social consumption only  drink -the following  beer  liquor  wine  
Quantity of \_\_\_\_ oz. per  day  week  month  
Substance  never use illegal drugs  has not used illegal drugs since? \_\_\_\_\_  used illegal drugs  
for (how long and what drugs) \_\_\_\_\_  
Hobbies \_\_\_\_\_ Stresses \_\_\_\_\_

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**Review of Systems:**

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  daytime drowsiness  fatigue  fever  night sweats  weight loss  weight gain

**Eye/Vision:**  I deny having any the symptoms listed below.

blindness  blurred vision  cataracts  change in vision  double vision  eye pain  
 glaucoma  itching  tearing  wear glasses/contacts  Other \_\_\_\_\_

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

bleeding  denture  difficulty swallowing  discharge  dizziness  ear discharge  ear pain  
 fainting  frequent sore throats  headaches (major/ minor/ migraine)  hearing loss  
 history of head injury  hoarseness  loss of sense of smell  nasal congestion  nose bleeds  
 sinus infection  Tinnitus (ringing in ears)  TMJ  Other \_\_\_\_\_

**Respiration:**  I deny having any the symptoms below.

asthma  coughing up blood  cough  shortness of breath  wheezing  Other \_\_\_\_\_

**Cardiovascular:**  I deny having any of the symptoms listed below.

angina (chest pain or discomfort)  heart murmur  heart problems  high blood pressure  low blood pressure  orthopnea (difficulty breathing lying down),  palpitations,  waking at with shortness of breath  shortness of breath with exercise  swelling of legs  ulcers  varicose veins  
 Other \_\_\_\_\_

**Gastrointestinal:**  I deny having any of the symptoms listed below.

abdominal pain  belching  black-tarry stools  constipation  diarrhea  difficulty swallowing  heartburn  hemorrhoids  indigestion  jaundice  nausea  rectal bleeding  abnormal stool size or color  vomiting  vomiting blood  Other \_\_\_\_\_

**Female:**  I deny having any symptoms or problems listed below.

birth control  breast lumps/pain  burning urination  cramps  frequent urination  pregnancy  
 urine retention  vaginal bleeding  vaginal discharge  Other \_\_\_\_\_

**Male:**  I deny having any of the symptoms listed below.

burning urination  erectile dysfunction  frequent urination  hesitancy/dribbling  prostrate  
problems  urine retention  Other \_\_\_\_\_

**Endocrine:**  I deny having any of the symptoms listed below.

cold intolerant  diabetes  excessive appetite  excessive hunger  excessive thirst  abnormal  
urination  goiter  hair loss  heat intolerance  unusual hair growth  voice changes  
 Other \_\_\_\_\_

**Skin:**  I deny having any of the following symptoms listed below.

changes in nail color  changes in skin color  hair growth  hair loss  hives  history of skin disorders  
 itching  parenthesis  rash  skin/lesions  varicosities  
 Other \_\_\_\_\_

**Nervous System:**  I deny having any of the following symptoms listed below.

dizziness  facial weakness  headache  limb weakness  loss of memory  numbness  seizures   
slurred speech  strokes  tremor  unsteadiness of gait/ loss of balance  
 Other \_\_\_\_\_

**Psychological:**  I deny having any of the symptoms or problems listed below.

anxiety  behavioral change  bi-polar disorder  convulsions  depression  insomnia  
 Other \_\_\_\_\_

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

amenia  bleeding  blood clotting  blood transfusion  bruising  fatigue  lymph node swelling  
 Other \_\_\_\_\_

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