

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

Family Physician: DR _____ Last Seen: _____ Treated for: _____

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

Hobbies _____ Stresses _____

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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