



**Confidential Patient Health Record**

DATE: \_\_\_\_\_

I.D. NO.: \_\_\_\_\_

**PERSONAL HISTORY**

Name: \_\_\_\_\_  
 Full Name MI Last Name Suffix Called Name

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  M  F

Social Security No.: \_\_\_\_\_ - - Driver's License No.: \_\_\_\_\_

Check One:  Married  Single  Widowed  Divorced  Separated

Work Status: \_\_\_\_\_ Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Pager No.: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Social Security Number: \_\_\_\_\_ - -

Spouse's Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Name and Ages of Children: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone Number of Emergency Contact: \_\_\_\_\_

Who is Responsible for your Bill: You and  Spouse  Workers' Comp.  Auto Ins.  Medicare  Medicaid

Personal Health Insurance: (Name) \_\_\_\_\_ Health Card No.: \_\_\_\_\_

Insured Person's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Condition Consulting this Office for: \_\_\_\_\_

Other Doctors Seen for this Condition:  Yes  No If Yes 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 Employers:  Yes  No

Drugs you now Take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine

Insulin  Other \_\_\_\_\_

Do you Wear a Shoe Lift?  Yes  No

Do you Suffer from any Condition other than that Which you are now Consulting Us?  Yes  No

If Yes Please Describe the Type of Condition: \_\_\_\_\_

## PAST HEALTH HISTORY

Please Check:

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 is 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 care.

### CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

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

Have you been tested HIV Positive?  Yes  No

### CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

#### GENERAL CODE

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

#### MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult chewing/Clicking Jaw
- General Stiffness

#### NERVOUS SYSTEM CODE

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

#### UROGENITAL CODE

- Bladder Trouble
- Painful/Excessive Urination

#### C-V-R CODE

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

#### GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

#### EENT CODE

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

#### 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

#### FAMILY HISTORY

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

<input type="checkbox"/> Mother	<input type="checkbox"/> Father
<input type="checkbox"/> Brother	<input type="checkbox"/> Sister
<input type="checkbox"/> Child	<input type="checkbox"/> Spouse

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the causes of the problem as well as the symptoms corrected and relieved (Corrective Care). You 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

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 or she deems appropriate. It is understood and agreed the 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 Written Authorization of Doctor's Notice of Privacy Practices

I acknowledge that I have read the copy of Jenkins Chiropractic LLC, Notice of Privacy Practices and fully understood same and have had all my questions answered to my satisfaction. I also understand that a copy of the doctor's Notice of Privacy Practices will be given to me **upon request.**

Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Consent to Treat a Minor \_\_\_\_\_

Date: \_\_\_\_\_

Guardian or Spouse's Signature of  
Authorizing Care \_\_\_\_\_

Date: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**ANALYSIS:** \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_

**Patient Accepted:**  Yes  No  Referred

**Doctor's Signature**

**Notes:**