Confidential Patient Health Record

Date _____/_____/_____

Care Chiropractic Center — Rehabilitation — Health & Wellness

Specializing in Sports Injuries and Rehabilitation

How did you hear about us? **Family _____ Doctor _____**

- **Co-Worker _____**
- **Friend _____**

Yellow pages Sign/Marquee Hospital Insurance Plan/Website Close to home/work Other _____

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs. Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III

Last: _____ First:_____ Middle: _____

Birth Date: _____ /_____/_____ Age: _____ Sex: Male / Female

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

Address: _____Apt # _____

City: _____ State: _____ Zip: _____

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

Cell Phone: (_____) _____-_____ ext _____ Other: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ First: _____Middle:_____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

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

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

Employment Information

Occupation/Job Title: _____ Job Description :_____

Business Name: _____

Employer's Email Address: _____

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

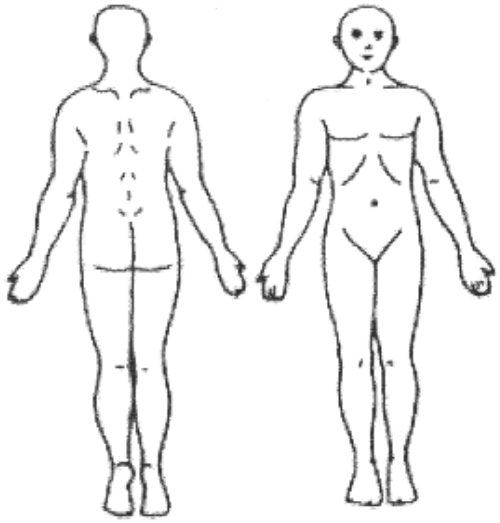
Current Health Condition

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

_____

Name _____ Date _____/ _____/_____
Last (Print) First Middle Initial

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

Explain: _____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Do you SUFFER with ANY OTHER condition other than that which you are now consulting us?_____

_____

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

Other doctors you have seen for this condition? (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**

Chiropractor: _____ **Location:** _____ **Date of Last Visit:** _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific. If you need more space use back.**

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

Medication allergies:_____

Intake: **Check all that apply below**

coffee **alcohol** **cigarettes/tobacco products**

tea **recreational drugs** **other** _____

caffeine

Name _____ Date _____/ _____/_____
Last (Print) First Middle Initial

Skin: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

☐ changes in nail texture ☐ hair loss ☐ itching ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ paresthesia (pins & needles) ☐ varicosities
☐ unusual hair growth ☐ history of skin disorders ☐ rash

Constitutional: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Eyes/Vision: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Ears, Nose & Throat: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Respiration: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Cardiovascular: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Gastrointestinal: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Endocrine: CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions. ☐ - I DENY having any of the conditions listed.

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

Name _____ Date _____/ _____/_____
Last (Print) First Middle Initial

Nervous System: **CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions.** ☐ **- I DENY** having any of the conditions listed.

☐ **dizziness**	☐ **limb weakness**	☐ **numbness**	☐ **slurred speech**	☐ **tremor**
☐ **facial weakness**	☐ **seizures**	☐ **stress**	☐ **headache**	☐ **unsteadiness of gait**
☐ **memory loss**	☐ **sleep disturbance**	☐ **loss of consciousness**	☐ **strokes**	**(loss of balance)**

Psychologic: **CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions.** ☐ **- I DENY** having any of the conditions listed.

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

Allergy: **CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions.** ☐ **- I DENY** having any of the conditions listed.

☐ **anaphylaxis**	☐ **chronic nasal congestion**	☐ **sneezing**	☐ **itching**
☐ **food intolerance**	☐ **acute nasal congestion**	☐ **rash**	☐ **other _____**

Food allergies_____

Hematologic: **CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions.** ☐ **- I DENY** having any of the conditions listed.

☐ **anemia**	☐ **blood clotting**	☐ **bruising easily**	☐ **lymph node swelling**
☐ **bleeding**	☐ **blood transfusion**	☐ **fatigue**	

Childhood Illness (es): **CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions.** ☐ **- I DENY** having any of the conditions listed.

☐ **ADD**	☐ **chicken pox**	☐ **headaches**	☐ **scoliosis**
☐ **atopic dermatitis (eczema)**	☐ **crohn's/colitis**	☐ **hepatitis**	☐ **seizure disorder**
☐ **allergies/hay fever**	☐ **depression**	☐ **HIV**	☐ **sickle cell anemia**
☐ **anemia**	☐ **diabetes**	☐ **measles**	☐ **other: _____**
☐ **asthma**	☐ **ear infections**	☐ **mumps**	**food allergies (list below)**
☐ **bedwetting**	☐ **fetal drug exposure**	☐ **psoriasis**	_____
	☐ **spina bifida**	☐ **rash**	_____

Adult Illness (es): **CHECK all CURRENT conditions. CIRCLE all PREVIOUS conditions.** ☐ **- I DENY** having any of the conditions listed.

☐ **ADD**	**cystic kidney disease**	**hypertension**	**psychiatric problems**
☐ **alzheimers**	**depression**	**influenza 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**	_____

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

Name _____ Date _____/ _____/_____
Last (Print) First Middle Initial

Surgery (ies): **CHECK 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	☐ tonsillectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other: _____
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	☐ other:

Injury (ies): **CHECK 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	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after 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:_____
other:_____	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	has/had:_____

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) ☐ **Myself ONLY** ☐ **Spouse**

☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Medicaid** ☐ **Other (be specific):**_____

Personal Health Insurance Carrier: _____**Health ID Card #:** _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Date of Birth: _____-_____-_____ **Primary Care Physician:** _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐ **Yes** ☐ **No** **Date:** ____/____/_____**Time:** _____**am/pm**

Carrier: _____ **Policy #** _____

Carriers Phone #: (_____) _____-_____ **Adjuster:** _____

Claim #: _____ *** Please provide us with a copy of the accident report.***

Name _____ Date _____/ _____/_____
Last (Print) First Middle Initial

Please check the type of care desired:

☐ **Relief Care** Relief Care is designed to relieve symptoms or pain only.

☐ **Corrective Care** Corrective Care relieves symptoms or pain while correcting the cause of the problem. (Corrective Care varies in its length of time, but is more lasting.)

☐ **Check here if you want the Doctor to select the type of care appropriate for your condition.**

To my knowledge, all of the information I have provided on this Personal History form is true and correct.

Patient's Signature X_____ Date _____/_____/_____

☐ Our office utilizes an open adjusting room, please check this box if you would prefer a private room.

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 help in the preparation of 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 deems appropriate through use of manipulation, adjustment, traction, and/or adjunctive procedures throughout my spine and/or extremity(ies). 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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

PERSONAL INSURANCE PATIENTS (i.e. Select Blue, etc.) - Most insurance companies have a deductible and/or co-payment. We will, as a courtesy, call your carrier and request specifications such that our billing procedures are accurate. Your insurance is an arrangement between you and your carrier. Care Chiropractic in no way guarantees these benefits are correct. Patients are financially responsible for all services rendered whether or not the services are covered or payable by their insurance carrier. We strongly urge you to call your member services number and verify your coverage.

Patient's Signature X _____ Date _____/_____/_____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____/_____/_____

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

Patient's Signature: X_____ Date: _____/_____/_____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I hereby authorize Dr. Stuart J. Surkosky, or members of his staff, to release any and all medical information and records, or copies of records, relating to attendance, examination of treatment rendered me, with the further privilege of personal examination of such records at any time hereafter to whomever he deems appropriate.

Patient's Signature X_____ Date _____/_____/_____