

PATIENT # \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# CONFIDENTIAL CLINICAL RECORD

## GENERAL INFORMATION - PLEASE PRINT

PATIENT NAME \_\_\_\_\_ HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOW LONG? \_\_\_\_\_

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEX: M - F \_\_\_ MARITAL STATUS M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ CHILDREN \_\_\_\_\_

YOUR EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ YEARS WITH FIRM \_\_\_\_\_

OCCUPATION \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_ / \_\_\_\_ / \_\_\_\_

DRIVERS LICENSE NO. \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ S.S. # \_\_\_\_ / \_\_\_\_ / \_\_\_\_ OCCUPATION \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ HOW LONG? \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PHONE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ DATE OF LAST PHYSICAL \_\_\_\_\_

DENTIST \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

DATE OF LAST CHIROPRACTIC ADJUSTMENT \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEEN BY DR. \_\_\_\_\_

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? \_\_\_\_\_

ADDRESS IF DIFFERENT \_\_\_\_\_ PHONE \_\_\_\_\_

WHO MAY WE CONTACT IN CASE OF EMERGENCY? \_\_\_\_\_

PHONE \_\_\_\_\_ WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

### MAJOR COMPLAINT

(Describe in your own words your problem and how it happened or started)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was the very first time you were aware of this problem?

\_\_\_\_\_

Have you ever had this problem or similar problem before? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever received any treatment for this condition? \_\_\_\_\_

If yes, when, where and what were the results?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

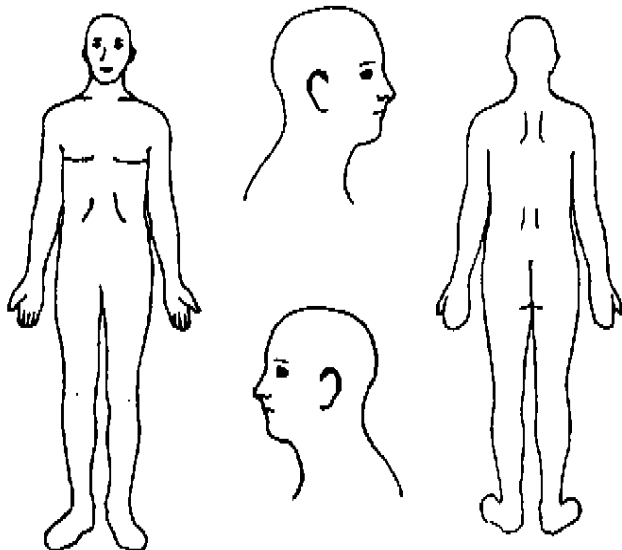
Is the problem better  worse  the same

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

\_\_\_\_\_

### COMPLETE THESE DIAGRAMS



How has this problem affected your life:

List all surgery you have had and the dates

- A. Home \_\_\_\_\_
- B. Work \_\_\_\_\_
- C. Recreation \_\_\_\_\_
- D. Rest and Sleep \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been in an automobile accident?  Never  Past Yr.  Past 5 Years  Over 5 Yrs.

Describe any other accidents or falls you have ever had \_\_\_\_\_

Have you ever? Been stunned or unconscious  Had broken bones  Used a cane or crutch  Been hospitalized  What for \_\_\_\_\_

Had a nervous breakdown

Had any major illness  Describe \_\_\_\_\_

DRUGS YOU NOW TAKE:  Nerve Pills  Pain Killers  Muscle Relaxers  "Pep" Pills  Tranquillizers  Insulin  Birth Control Pills  Other (please list) \_\_\_\_\_

Have you or any of your blood relatives had?  High Blood Pressure  Venereal Disease

Tuberculosis  Heart Disease  Diabetes  Arthritis  Epilepsy  Cancer  Polio

Habits: fill in number or check those that apply

No. hours sleep \_\_\_\_\_ Exercise routinely  Do you smoke

How many cups or glasses \_\_\_\_\_  tea \_\_\_\_\_  coffee \_\_\_\_\_  soda \_\_\_\_\_  alcohol

Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff.

**GENERAL SYMPTOMS**

- 784.0 Headache
- 346.9 Migraine headache
- 780.8 Night Sweating
- 780.2 Fainting
- 780.4 Dizziness
- 780.3 Convulsions
- 780.52 Loss of sleep
- 780.7 Fatigue
- 799.2 Nervousness
- 783 Loss of weight
- 278.0 Obesity
- 995.3 Allergy
- 781 Tremors

**E.E.N.T.**

- 368.9 Failing vision
- 389.9 Deafness
- 388.70 Earache
- 388.30 Ear noises
- 784.7 Nose bleeds
- 462 Sore throat
- 493.9 Asthma
- 460 Frequent colds
- 240.9 Enlarged thyroid
- 686.9 Sinus problems

**SKIN**

- 698.9 Itching
- 287.8 Bruises easily
- 701.1 Dryness
- 454.9 Varicose veins
- 782 Sensitive skin

**RESPIRATORY**

- 786.2 Chronic cough
- 786.50 Chest pain
- 786.09 Pain or difficulty breathing with exercise

**CARDIO-VASCULAR**

- 785 Rapid beating heart
- 427.89 Slow beating heart
- 401.9 High blood pressure
- 458.9 Low blood pressure
- 786.51 Pain over heart
- 719.07 Swelling of ankles  
Right  Left
- 436 Paralytic stroke

**MUSCLE & JOINT SYMPTOMS**

- 716.9 Arthritis
- 782 Numbness/pain in arms, hands, or legs, toes
- 719 Swollen joints
- 719.7 Difficulty in walking
- 722.10 Low back pain
- 722.2 Disc displacement
- 723.1 Pain in neck
- 723.5 Stiff neck
- 724.1 Pain between shoulders
- 724.79 Painful tailbone
- 728.85 Muscle spasms
- 729.4 Foot trouble
- 737 Faulty posture
- 737.3 Spinal curvature
- 781 Tremors
- \_\_\_\_\_ Shoulder pain
- \_\_\_\_\_ Knee pain
- \_\_\_\_\_ Elbow pain
- \_\_\_\_\_ Ankle pain

**GENITOURINARY SYMPTOMS**

- 788.3 Frequent urination
- 788.1 Painful urination
- 592 Kidney infection/stones
- 601.9 Prostate trouble

**GASTROINTESTINAL SYMPTOMS**

- 783 Poor appetite
- 994.2 Excessive hunger
- 787.3 Belching or gas
- 787 Nausea or Vomiting
- 536.8 Pain over stomach
- 564 Constipation
- 558.9 Diarrhea
- 789 Colon trouble
- 455.6 Hemorrhoids (Piles)
- 575.9 Gall bladder trouble
- 558.9 Colitis

**FOR WOMEN ONLY**

- 611.72 Lumps in breast
- 623.5 Vaginal discharge
- 625.3 Painful menstrual periods
- 626.2 Excessive flow
- 626.4 Irregular cycle
- 627.2 Menopausal symptoms
- Date of last period \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Are you pregnant? \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of live births \_\_\_\_\_
- Birth Control method \_\_\_\_\_

Signature \_\_\_\_\_  
Patient/Guardian