



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 | INTAKE: |
| <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: