

**Confidential Patient Health Record**

**Today's Date:** \_\_\_ / \_\_\_ / \_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  Newspaper  
 Dr. \_\_\_\_\_  Yellow pages  Drove by  Hospital  Insurance Plan

**Personal Information**

**Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

**Suffix:**  Jr  Sr  II  III

**Birth Date:** \_\_\_ / \_\_\_ / \_\_\_ **Age:** \_\_\_\_\_ **Sex:** Male / Female **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Driver's License #:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Blood Type:**  A positive  A negative  B positive  B negative  AB positive  AB negative  O positive  O negative

**Race:**  African American  Asian  Caucasian  Hispanic  Multiracial  Native American  Other: \_\_\_\_\_

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

**Eye Color:**  blue  brown  green  grey  hazel  other: \_\_\_\_\_

**Hair Color:**  black  blonde  brown  gray  red  white  other: \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt #** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Country:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

**Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

**Spouses Name:** \_\_\_\_\_

**Children (Names and Ages):** \_\_\_\_\_

**Emergency Contact**

**Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **Middle:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt #** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Country:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Relationship:**  Spouse  Relative  Friend  Other \_\_\_\_\_

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ **Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

**Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

**Employment Information**

**Business Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt #** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Country:** \_\_\_\_\_ **County:** \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Fax #:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

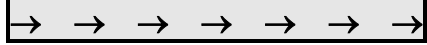
**Occupation/Job Title:** \_\_\_\_\_ **Job Description** \_\_\_\_\_

**Current Health Condition**

Unwanted Condition (Why you are here today?): \_\_\_\_\_

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

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

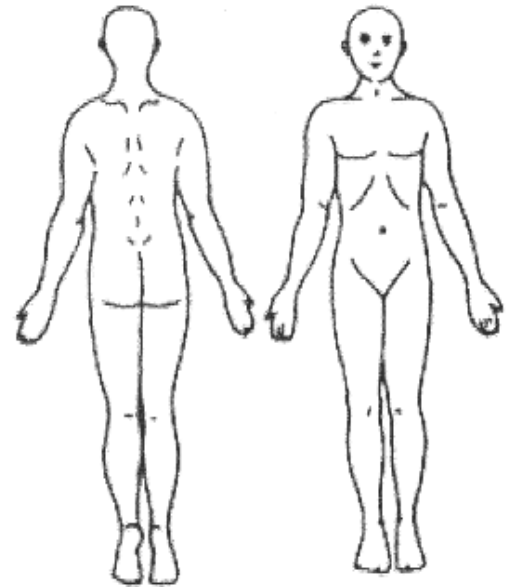
Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am /pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



**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
- fatigue
- night sweats
- weight loss
- daytime drowsiness
- fever
- weight gain

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

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

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

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

**Respiration:**  I DENY having any of the symptoms or problems listed below.

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

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

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

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

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

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control       cramps       irregular menstruation       vaginal bleeding  
 breast lumps/pain       frequent urination       pregnancy       vaginal discharge  
 burning urination       hormone therapy       urine retention

**Male:**  I DENY having any of the symptoms or problems listed below.

- burning urination       frequent urination       prostate problems  
 erectile dysfunction       hesitancy/ dribbling       urine retention

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- cold intolerance       excessive hunger       goiter       unusual hair growth  
 diabetes       excessive thirst       hair loss       voice changes  
 excessive appetite       abnormal frequency of urination       heat intolerance

**Skin:**  I DENY having any of the symptoms or problems listed below.

- changes in nail texture       hair loss       itching       skin lesions / ulcers  
 changes in skin color       hives       paresthesias       varicosities  
 hair growth       history of skin disorders       rash

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- dizziness       limb weakness       numbness       slurred speech       tremor  
 facial weakness       loss of consciousness       seizures       stress       unsteadiness of gait/ loss of balance  
 headache       loss of memory       sleep disturbance       strokes

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

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

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- anaphalaxis       itching       chronic nasal congestion       sneezing  
 food intolerance       acute nasal congestion       rash

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- anemia                       blood clotting                       bruising easily                       lymph node swelling  
 bleeding                       blood transfusion                       fatigue

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

**Previous Care for this Same Condition:**

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Were you satisfied with the results of your treatment?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Were you satisfied with your care?  Yes  No. Why? \_\_\_\_\_

Do you wear any of the following?  Heel Lifts  Innersoles  Arch Supports  Orthotics  Other \_\_\_\_\_

For how long? \_\_\_\_\_ Were they prescribed by a doctor?  Yes or  No.

**Current Medication (s):** List ANY/ALL medications you are CURRENTLY taking. Be Specific.

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

**Current Vitamins, Herbs, etc:** List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

**Childhood Illness (es):** LIST all health conditions. CIRCLE all CURRENT conditions.

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

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition?  yes or  no.

**Adult Illness (es):** LIST all health conditions. CIRCLE all CURRENT conditions.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD             | <input type="checkbox"/> cystic kidney disease  | <input type="checkbox"/> hypertension                 | <input type="checkbox"/> psychiatric problems             |
| <input type="checkbox"/> alzheimers      | <input type="checkbox"/> depression             | <input type="checkbox"/> influenzal pneumonia         | <input type="checkbox"/> scoliosis                        |
| <input type="checkbox"/> anemia          | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease                | <input type="checkbox"/> seizures                         |
| <input type="checkbox"/> arthritis       | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease                 | <input type="checkbox"/> shingles                         |
| <input type="checkbox"/> asthma          | <input type="checkbox"/> eczema                 | <input type="checkbox"/> lupus erythema (discoïd)     | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer          | <input type="checkbox"/> emphysema              | <input type="checkbox"/> lupus erythema (systemic)    | <input type="checkbox"/> STD's (unspecified)              |
| <input type="checkbox"/> cerebral palsy  | <input type="checkbox"/> eye problems           | <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> suicide attempt(s)               |
| <input type="checkbox"/> chicken pox     | <input type="checkbox"/> fibromyalgia           | <input type="checkbox"/> parkinson's disease          | <input type="checkbox"/> thyroid problems                 |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease          | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo                          |
| <input type="checkbox"/> CRPS (RSD)      | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> pneumonia                    | <input type="checkbox"/> other:                           |
| <input type="checkbox"/> CVA (stroke)    | <input type="checkbox"/> HIV                    | <input type="checkbox"/> psoriasis                    |   |

**Surgery (ies):** LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> angioplasty             | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy            | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section       | <input type="checkbox"/> dental sugery    | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsilectomy        |
| <input type="checkbox"/> carpal tunnel repair    | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other:              |
| <input type="checkbox"/> coronary artery bypass  | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           |  |

**Females ONLY: Ob/Gyn** Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

Number of complicated pregnancies	Number of uncomplicated pregnancies
Number of C-sections	Number of vaginal deliveries
Number of miscarriages	Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

**Menstrual History**

I... <input type="checkbox"/> currently have menses.	<input type="checkbox"/> currently DO NOT have menses.
My menses... <input type="checkbox"/> are regular.	<input type="checkbox"/> are NOT regular.
Age of first menses	Age when metaphase began
Date of last menses:     /     /	

**Injury (ies):** Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> back injury      | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident        |
| <input type="checkbox"/> broken bones     | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild)     |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident                    | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe)    | <input type="checkbox"/> joint injury                           | <input type="checkbox"/> soft tissue injury (severe)   |
| <input type="checkbox"/> fracture         | <input type="checkbox"/> laceration (severe)                    | <input type="checkbox"/> other:                        |

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**Social History: Mark all that apply below.**

Alcohol:  do not drink alcohol  social consumption only  drink the following regularly (mark below)  
 beer  liquor  wine; quantity of \_\_\_\_\_ oz./glasses per  day  week  month

My Dietary Intake consists mainly of the following: (mark all that apply)

- |                                       |   |                                    |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> high fat     | <input type="checkbox"/> high salt        | <input type="checkbox"/> low fiber |
| <input type="checkbox"/> high fiber   | <input type="checkbox"/> low calorie      | <input type="checkbox"/> low salt  |
| <input type="checkbox"/> high protein | <input type="checkbox"/> low carbohydrate | <input type="checkbox"/> low sugar |

Mark the highest level of Education completed:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> in pre-school        | <input type="checkbox"/> in high school           | <input type="checkbox"/> in college        | <input type="checkbox"/> doctorate          |
| <input type="checkbox"/> in elementary school | <input type="checkbox"/> high school graduate     | <input type="checkbox"/> college graduate  | <input type="checkbox"/> in graduate school |
| <input type="checkbox"/> in middle school     | <input type="checkbox"/> GED                      | <input type="checkbox"/> associates degree | <input type="checkbox"/> graduate degree    |
|   | <input type="checkbox"/> high school – incomplete | <input type="checkbox"/> bachelors degree  | <input type="checkbox"/> other: _____       |

Substance:  never used illegal drugs  has not used illegal drugs since \_\_\_\_\_ .  
 never used IV drugs  used illegal drugs for \_\_\_\_\_ (how long?)

Tobacco:  Do not use tobacco  Do not smoke cigars, cigarettes or pipe  Live with a smoker  Quit smoking  
 Smoke: # \_\_\_ per  Day  Week  Month;  Chew: # \_\_\_\_\_ cans per  Day  Week  Year

**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 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 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 #: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic 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 Chiropractic Clinic will be credited to my account upon 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 my care or treatment, 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 through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative 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.

I hereby authorize the providers of Linn Chiropractic Center to administer such procedures as may be deemed necessary in the diagnosis and treatment of the patient. I hereby authorize release of any medical information regarding this visit to my insurance and or primary care physician, and also ASSIGN to the Provider all payments from Medicare, Midlands Choice, Blue Cross/Blue Shield, Medicaid, and my insurance if not listed. I Understand that I am financially responsible for all charges whether or not paid by my insurance.

I Understand that not all providers at Linn Chiropractic Center may be a participating provider with my insurance. I Understand that I am responsible for the charges not covered by my insurance. A late fee of \$17.50 will be added to all accounts unpaid for 90 days. I will also be liable for all legal and collection fees. I understand and Agree to the above conditions.

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

Patient Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consent to treat a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

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

---

**Payment for services is due on the day of service. As part of our service, we will submit your claim to your insurance.**

---

### **VERIFICATION OF NOT PREGNANT (for females only)**

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_