

Confidential Patient Health Record

Date: ___/___/___

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ___/___/___ Age: ___
First: ___ Middle: ___ Last: ___ Gender: Male / Female
Address: ___ Apt # ___
City: ___ State: ___ Zip: ___ County: ___ Country: ___
Home Phone: (___) ___-___ Cell Phone: (___) ___-___
Social Security #: ___-___-___ Fax #: (___) ___-___
Driver's License #: ___ State: ___ Email Address: ___
Spouses Name: ___
Ages of Children: ___

Employer

Business Name: ___ Occupation/Job Title: ___
Business Address: ___
Business Phone: (___) ___-___ Type of Work: ___

How did you hear about us? _____

Emergency Contact

Name: ___ Phone Number: (___) ___-___
Address: _____
Relationship: _____

Who Is Responsible For Your Bill?

Self Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: ___-___-___ Pharmacy: _____
Claims Address: _____
Secondary Insurance Name: _____ Secondary Insurance #: _____
Insured's Name: _____ Insured's Date of Birth: _____
Secondary Claims Address: _____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

Use the letters below to indicate the type and location of you sensations right now:
A=Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ___/___/___

Has it ever occurred before? Yes No

When? _____

Is the condition: Auto Related Work Related
 No Injury Other

Explain: _____

Date of Accident: _____

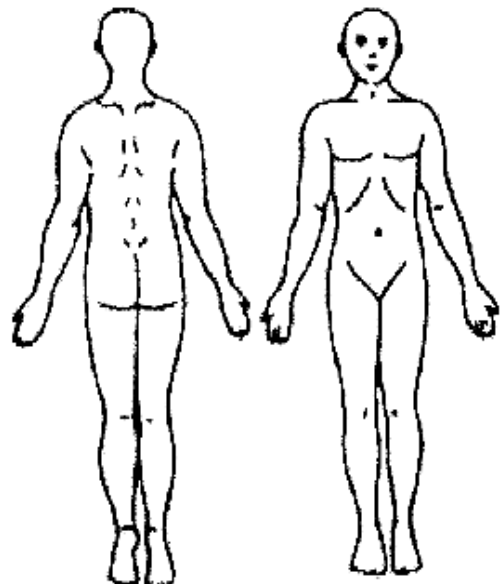
Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work Related: _____

Have you filed an injury report with your employer? Yes No

Claim #: _____



Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Date: _____

Chief Complaint: _____

Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New Recurring Exacerbation Chronic

Mechanism of Onset:

- Auto (see accident history form)
- Work... Fall Lifting Overexertion Repetitive Motion Other (see accident history form)
- Other... Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall
- No Injury (see below)

Symptoms: Pain Numbness Stiffness Weakness

Location: Left /Right /Bilateral _____

Quality: Burning Diffuse Dull/Aching Localized Sharp Shooting Stabbing
 Throbbing Tightness Tingling Radiating Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Symptom(s)Started: _____ Symptom(s) Worsened: _____ Symptom(s)Last Occurred: _____
Symptom(s)Last Episode: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: Worse in the: Morning Afternoon Night With Activity Constant Intermittent

Context: Better with: Warm Temp Cold Temp Worse with: Warm Temp Cold Temp Damp

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Headaches (see below)
 Irritability/Mood Swing Localized Tingling Nausea Ringing in Ears Stiffness

Headaches: (continued) Location: Occipital Frontal Temporal Parietal Sinus
Quality: Dull Sharp Throbbing Stabbing Aura No Aura
Types: Hat Band Cluster Migraine Tension

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms: Aches Cold Limb Dizziness Ecchymosis
 Fatigue Fever Heartburn Muscle Spasm Nausea Numbness
 Pale Bluish Skin Panic Pins & Needles Runny Nose SOB Stiffness
 Sweating Swelling Tingling Vomiting Weakness

Modifying Factors:

Symptoms Better With: Activity Bending Cold Heat Massage
 Movement OTC Meds Rx Meds Rest Stretching Sitting
 Standing Twisting Walking Nothing Helps

Symptoms Worse With: (as noted in Social History)

Have you seen other doctors for this condition? Yes No If yes, Who? (Name) _____

Location of Office: _____ Type of Treatment: _____

Were you satisfied with the results of your treatment? Yes No Explain: _____

Are you currently taking any prescription medications? Yes No. If yes, please mark or list below (be specific).

Allergy Medication Anti-Depressants Blood Pressure Medication Insulin Muscle Relaxers
 Nerve Pills Pain Killers Other (please be specific): _____

Do you wear any of the following? Yes No. If yes, please mark: Heel Lifts Innersoles Arch Supports Orthotics

Please list any other conditions you feel we should know about – even if unrelated: _____

Below is a list of diseases 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.

REVIEW OF SYSTEMS – Please fill out all of the sections, even if “DENY”.

Constitutional: I... Deny Any Constitutional Issue (s)

- Chills Daytime Somnolence (Drowsiness) Fatigue Fever Night Sweats
 Weight Gain Weight Loss

Eyes/Vision: I... Deny Any Eyes/Vision Issue (s)

- Blindness Blurred Vision Cataracts Change in vision Double Vision
 Eye Pain Field Cuts (visual field defect) Glaucoma Itching (around the eyes) Photophobia
 Tearing Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I... Deny Any Ears, Nose and Throat Issue (s)

- Bleeding Dental Implants Dentures Difficulty Swallowing Discharge
 Dizziness Ear Drainage Ear Infection(s) Ear Pain Fainting
 Headaches Head Injury (history of) Hearing Loss Hoarseness Loss of Smell
 Nasal Congestion Nose bleeds (frequent) Post Nasal Drip Rhinorrhea (Runny nose) Sinus Infections
 Snoring Sore Throats (frequent) Tinnitus (Ringing in Ears) TMJ problems

Respiration: I... Deny Any Respiratory Issue (s)

- Asthma Cough Coughing up blood Shortness of Breath Sputum Production Wheezing

Cardiovascular: I... Deny Any Cardiovascular Issue (s)

- Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur
 Heart Problems Orthopnea (difficulty breathing while lying down) Palpitations (irregular or forceful beating of the heart)
 Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) Shortness of Breath with Exertion or Exercise
 Swelling of Legs Ulcers Varicose Veins

Gastrointestinal: I... Deny Any Gastrointestinal Issue (s)

- Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea
 Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin)
 Nausea Rectal Bleeding Abnormal Stool Caliber (quality) Abnormal Stool Color
 Abnormal Stool Consistency Vomiting Vomiting Blood

Female: I... Deny Any Female Issue (s)

- Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination
 Hormone Therapy Irregular Menstruation Urine Retention Vaginal Bleeding Vaginal Discharge

Male: I... Deny Any Male Issue (s)

- Burning Urination Erectile Dysfunction Frequent Urination Hesitancy/Dribbling Prostate Problems
 Urine Retention

Endocrine: I... Deny Any Endocrine Issue (s)

- Cold Intolerance Diabetes Excessive Appetite Excessive Hunger Excessive Thirst
 Frequent Urination Goiter Hair Loss Heat Intolerance Unusual Hair Growth
 Voice Changes

Skin: I... Deny Any Skin Issue (s)

- Changes in Nail Texture Changes in Skin Color Hair Growth Hair Loss Hives Itching
 Paresthesia (numbness, prickling, or tingling) Rash History of Skin Disorders Skin Lesions/Ulcers Varicosities

Nervous System: I... Deny Any Nervous System Issue (s)

- Dizziness Facial Weakness Headaches Limb Weakness Loss of Consciousness
 Loss of Memory Numbness Seizures Sleep Disturbance Slurred Speech
 Stress Strokes Tremors Unsteadiness of Gait

Psychologic: I... Deny Any Psychologic Issue (s)

- Anhedonia (inability to experience joy or enjoy life) Anxiety Appetite Changes Behavioral Change(s)
- Bipolar Disorder Confusion Convulsions Depression Insomnia Memory Loss Mood Change(s)

Allergy: I... Deny Any Allergy Issue (s)

- Anaphylaxis (history of) Food Intolerance Itching Nasal Congestion Sneezing

Hematology: I... Deny Any Hematologic Issue (s)

- Anemia Bleeding Blood Clotting Blood Transfusion(s) Bruises easily Fatigue Lymph Node Swelling

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

Childhood Illness: I... Deny Any Childhood Illness (es)

- ADD Allergies/Hayfever Asthma Atopic Dermatitis (Eczema) Bedwetting
- Cerebral Palsy Chicken Pox Depression Diabetes Ear Infections
- Fetal Drug Exposure Food Allergies Headaches Hepatitis HIV
- Measles Mumps Rash Scoliosis Seizure Disorder
- Sickle Cell Anemia Spina Bifida Other (please describe): _____

Adult Illness: I... Deny Any Adult Illness (es)

- Alzheimers Anemia Arthritis Asthma Cancer
- Chicken Pox Crohn's/Colitis CRPS (RSD) CVA (stroke) Cystic Kidney Disease
- Depression Diabetes (Insulin) Diabetes (Non insulin) Ear Infections (frequent) Emphysema
- E ye Problems Fibromyalgia Heart Disease Hepatitis HIV
- Hypertension Influenzal Pneumonia Liver Disease Lung Disease Lupus Erythema (discoid)
- Lupus Erythema (systemic) Multiple Sclerosis Parkinson's Disease Pleurisy Pneumonia
- Psychiatric Problems Scoliosis Seizure Disorder Shingles STD's (unspecified)
- Suicide Attempt(s) Thyroid Problems Vertigo
- Past history of similar symptoms to your current condition Other Illness (please be specific): _____

Surgeries: I... Deny Any Surgery (ies)

- Angioplasty Appendectomy Caesarian Section Cardiac Catheterization Carpal Tunnel Repair
- Coronary Artery Bypass Cosmetic D & C Dental Surgery Gallbladder
- Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction Joint Replacement
- Laminectomy Mastectomy Pacemaker Insertion Rotator Cuff Spinal Fusion
- Tonsilectomy Other (please be specific): _____

Ob/Gyn: I... Deny Any Ob/Gyn Issue (s)

- I... have never been pregnant have been pregnant in the past am currently pregnant
- _____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
- _____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
- _____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _____

My menses is Regular Irregular; I am currently in Metaphase Menopause; Date of Last Menses ____/____/____

Since condition began, has anything permanently helped you? YES NO

Has anything that you have done, thus far, fixed you problem? YES NO

Employment:

Occupation: _____ Work (hrs/day): _____

Job Classification: Sed (<5lbs) Light (6-20lbs) Moderate (21-49lbs) Heavy(>50 lbs)

Lifting Frequency: Constant (66-100%/day) Frequent (33-65%/day) Occasional (0-32%/day)

Lifting Postures: Torso Knee Arm Shoulder High Near Off Posture

Work Activity Postures: (hrs/day)

Sitting: _____ Standing: _____ Walking: _____ Climbing: _____ Pushing: _____ Pulling: _____

Kneeling: _____ Reaching: _____ Twisting: _____

Repetitive Activities: (hrs/day)

Computer: _____ Phone: _____ Machinery: _____ Hand Tools: _____ Assembly: _____ Grasping: _____

Condition's Effect On Job Performance:

- Mild Painful (can do) Mod Painful (limits ability) Mod/Sev (limited duty) Sev (no limited duty) Sev (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Care –Infirm Family: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Carrying Groceries: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Change Posn–Sit–Stand: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Climb Stairs: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Daily Pet Care: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Driving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Ext Computer Use: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Household Chores: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Lift Children: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Bathing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Dressing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Self Care–Shaving: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sexual Activities: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Sleep: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Sitting: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Static Standing: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Walking: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform
- Yard Work: No Effect Mild Painful (Can do) Mod Painful (Limited) Sev Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform
- _____ No Effect Mild Painful (Can do) Mod Painful (limited) Sev Unable to Perform

Injuries:

I... Deny Any Injury (ies)

- Back Injury Broken Bones Severe Fall Fracture Disability
- Head Injury Industrial Accident Joint Injury Severe Laceration Motor Vehicle Accident
- Mild/Moderate Soft Tissue Injury Severe Soft Tissue Injury

Immunizations:

I... Deny Any Immunization (s)

- DTaP(diphtheria, tetanus, and pertussis) Flu Hepatitis A Hepatitis B Hepatitis C
- Influenza IPV (Polio) MMR (measles, mumps, and rubella) Pneumococcal
- PPD (Mantoux Test-TB) Small Pox TB Varivax (chicken pox) Whooping Cough (Pertussis)

Non-Drug Allergies:

I... Deny Any Non-Drug Allergy (ies)

- Animals Dairy Eggs Food Coloring Mold Pollen Wheat
- Other (please be specific): _____

Family History

Condition (please be specific)

- General Family** Alive Deceased; Normally Developed No Significant Disease 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: _____

Social History

Alcohol: Never Social Consumption only Beer Liquor Wine ; _____ oz _____ glasses; Day Week Month

Diet (please mark all that apply): High Fat High Fiber High Protein High Salt
 Low Calorie Low Carb Low Fiber Low Salt Low Sugar

Education (please mark the highest level completed): Preschool Elementary Middle Junior High Votech
 In High School Did Not Finish High School High School Diploma Post High School Classes Assoc/Technical Degree
 In College College Degree In Graduate School Graduate Degree Doctorate Other: _____

Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____ Have used drugs for _____

Tobacco: Deny Tobacco Use Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking

Smoke; # _____ per Day Week Month Chew; # _____ cans per Day Week Year

Signature: _____ Date: _____