GEHMAN CHIROPRACTIC
39 Market Street
Hatfield, PA 19440
215-362-5949

CONFIDENTIAL HEALTH INFORMATION

Name:_____ Social Security _____ Date: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Work #: _____

E-Mail: _____Age: _____ Birth Date: _____ Marital Status: M S W D

Employer: _____ May We Contact You At Work: ____ Yes _____ No

Employer Address: _____ Occupation: _____

Spouse / Partner Name: _____ Occupation: _____

Spouse / Partner Employer: _____

Emergency Contact Name: _____ Phone #: _____

Referred By: _____ Medical Dr's. Name: _____

May we contact your primary doctor about your care? _____ Yes _____ No

Insurance Information: _____ Health Insurance _____ Auto _____ Workers Comp

_____ Medicare _____ Health Savings Acct / Flex Plan _____ No Insurance

Insurance Carrier: _____ Group #: _____ ID#: _____

I understand and agree that health insurance policies are an agreement between the insurance carrier and myself, and 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 and treatment, any fees for professional services rendered me will be immediately due and payable.

What Prompted You To Seek Care? _____

Other Symptoms/Complaints: _____

Nature Of Injury: Auto _____ Work _____ Sports _____ Other _____

Date Symptoms/Injury Occurred: _____ Days Lost From Work: _____

Ever Had Same/Similar Condition? _____ Yes _____ No If Yes, When? and Please Describe _____

_____

Have You Previously Treated For This Condition? _____Yes _____No

If Yes, How? and With Whom? _____

Is Condition Improving _____ Worsening _____ Same _____ Is It Constant? _____ Does It Come & Go _____

Does Your Pain Radiate To Other Areas: _____

What Makes Your Condition Worse: _____

What Makes It Feel Better: _____

What Do Your Symptoms Feel Like? Ache ____ Sharp ____ Stiff _____ Tingling _____ Numb _____

Burning _____ Throbbing _____ Cramps _____ Stabbing _____

What **Activities of Daily Living** does your pain / condition interfere with?

_____	Sleeping	_____	Bathing	_____	Self Care	_____	Working	_____	Walking
_____	Showering	_____	Family Care	_____	Lifting	_____	Standing	_____	Dressing
_____	Child Care	_____	Desk Work	_____	Sitting	_____	Shoes	_____	Home Care
_____	Traveling	_____	Running	_____	Toileting	_____	Driving	_____	School
_____	Climbing	_____	Cleaning	_____	Gardening	_____	Concentration		

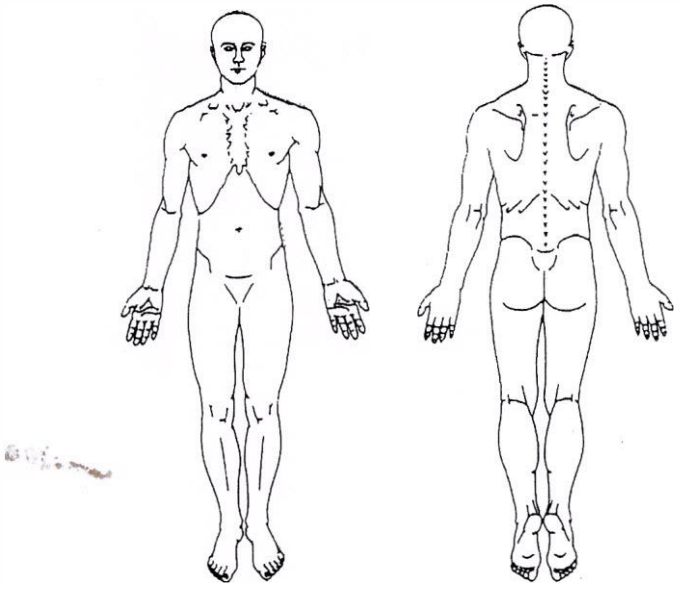
Patient Name: _____ Date: _____

Pain Diagram

Instructions: Mark the location of **Your** symptoms using these symbols:

Sharp Pain XXXXXX Numb/Tingling ++++++

Dull Pain 00000000 Other _____



Pain Scale

Instructions: Indicate your level of pain by choosing the appropriate number on the scale below:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain				Very Severe Pain	

PREVIOUS CARE:

Have you been to a Chiropractor before? _____ Yes _____No If yes, what for? _____

How long did you treat? _____ Was your problem resolved? _____ Yes _____ No

Have you been treated for any health condition in the past year? _____Yes _____No If yes, for what, and with whom?

_____

Have you had any previous _____Injuries, _____Falls, _____ Auto Accidents, _____Work Injuries, _____ Broken Bones

List any Surgeries you've had: _____

List any Prescription Medications: _____

Do you take Vitamins? _____ Yes _____ No

Indicate your Stress Level: 0 1 2 3 4 5

MILD - HIGH

Is your job very physical? _____ Yes _____No Does it involve repetitive motions? _____Yes _____ No

Any other health concerns? _____

_____

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑Previously ❑Presently

Previously	Presently	GENERAL SYMPTOMS
❑	❑	Allergy(What) ____ _____
❑	❑	Bronchitis
❑	❑	Chills (Constant)
❑	❑	Convulsions
❑	❑	Dizziness
❑	❑	Fainting
❑	❑	Fatigue
❑	❑	Headache
❑	❑	Loss of Sleep
❑	❑	Loss of Weight
❑	❑	Nervousness
❑	❑	Night Sweats
❑	❑	Numbness or Pain in arms/legs/hands
❑	❑	Wheezing

Previously	Presently	GASTRO-INTESTINAL
❑	❑	Belching or Gas
❑	❑	Colon Trouble
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Gall Bladder Trouble
❑	❑	Hemorrhoids (piles)
❑	❑	Jaundice
❑	❑	Liver Trouble
❑	❑	Nausea
❑	❑	Stomach Pain
❑	❑	Vomiting
❑	❑	Vomiting Blood
❑	❑	Heart Burn
❑	❑	Bloody Stools
❑	❑	Acid Reflux
❑	❑	Irritable Bowel

Previously	Presently	EYE/EAR NOSE/THROAT
❑	❑	Asthma
❑	❑	Deafness
❑	❑	Earache
❑	❑	Ear Discharge
❑	❑	Ear Noises
❑	❑	Thyroid Problems
❑	❑	Frequent Colds
❑	❑	Hay Fever
❑	❑	Nasal Obstruction
❑	❑	Nose Bleeds
❑	❑	Pain in Eyes
❑	❑	Poor Vision
❑	❑	Blurred Vision
❑	❑	Sinusitis
❑	❑	Sore Throats
❑	❑	Tonsillitis

Previously	Presently	RESPIRATORY
❑	❑	Chest Pain
❑	❑	Chronic Cough
❑	❑	Difficulty Breathing
❑	❑	Spitting Blood
❑	❑	Spitting Phlegm

GENITO-URINARY

❑	❑	Bed Wetting
❑	❑	Blood in Urine
❑	❑	Frequent Urination
❑	❑	Inability to Control Urine
❑	❑	Kidney Infection
❑	❑	Kidney Stones
❑	❑	Painful Urination
❑	❑	Prostate Trouble

MUSCLES & JOINTS		CARDIO-VASCULAR		SKIN OR ALLERGIES		FOR FEMALES ONLY	
❑	❑ Backache	❑	❑ High Blood Pressure	❑	❑ Bruising Easily	❑	❑ Cramps
❑	❑ Foot Trouble	❑	❑ Low Blood Pressure	❑	❑ Dryness	❑	❑ Hot Flashes
❑	❑ Hernia	❑	❑ Chest Pain	❑	❑ Eczema	❑	❑ Irregular Cycle
❑	❑ Pain Between Shoulders	❑	❑ Heart Trouble	❑	❑ Hives or Allergy	❑	❑ Painful Periods
❑	❑ Painful Tail Bone	❑	❑ Poor Circulation	❑	❑ Itching	❑	❑ Vaginal Discharge
❑	❑ Stiff Neck	❑	❑ Rapid Heart	❑	❑ Sensitive Skin		
❑	❑ Spinal Curvature	❑	❑ Slow Heart	❑	❑ Skin Eruptions	❑Yes	❑No Pregnant at this Time
❑	❑ Swollen Joints	❑	❑ Strokes			_____	Last Pap Date
❑	❑ Tremors	❑	❑ Swelling Ankles			_____	Last Menstrual Cycle
		❑	❑ Varicose Veins				

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑ Appendicitis	❑ Anemia	❑ Heart Disease	❑ Arthritis	❑ Pneumonia	❑ Measles
❑ Goiter	❑ Epilepsy	❑ Rheumatic Fever	❑ Mumps	❑ Influenza	❑ Depression
❑ Polio	❑ Chicken Pox	❑ Pleurisy	❑ Lumbago	❑ Tuberculosis	❑ Diabetes
❑ Alcoholism	❑ Eczema	❑ Whooping Cough	❑ Cancer	❑ Venereal Disease	❑ HIV Positive

HABITS

❑ Smoking	Packs/day: _____
❑ Drinking	Alcohol: (Cups/day) _____
❑ Coffee	Cups/Day: _____
❑ Soft Drink	Bottles or Cans/Day: _____
❑ Water	Cups/Day: _____

EXERCISE

❑ None	
❑ Moderate	
❑ Daily	
Type: _____	
_____	

FAMILY HISTORY

	Diabetes	Heart	Cancer	Back
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Brother(s), # of_____	❑	❑	❑	❑
Sister(s), # of _____	❑	❑	❑	❑

I understand and agree to allow this Chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your patient Health Information is going to be used in this office, your rights concerning those records, and that your personal information will be kept strictly confidential. You may request for your records, a copy of our Privacy Policy concerning your personal information. If there is anyone you do not want to receive your medical records, please inform us.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

NOTES: