Date: ___________ Acct. #: ___________

POINTE VILLAGE CHIROPRACTIC
Confidential Health Record

Thank you for choosing Pointe Village Chiropractic for your medical care. Please complete this Health Record, if something does not apply write N/A in the blank.

NAME: ________________________________ BIRTHDATE: ___________ AGE: _____
GENDER: ☐ Male ☐ Female MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
RACE: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Middle Eastern
LANGUAGE SPOKEN: ____
ADDRESS: ____
NUMBER & STREET CITY STATE ZIP

Cell phone: ______________ Home Phone: ____________ Work Phone:______________
E-mail: __________________
PREFERRED CONTACT Method: ☐ E-mail ☐ Phone (Cell, Home, Work) ☐ Patient portal
EMERGENCY CONTACT: ________________________Relationship: ____________
Phone:____________
HOW DID YOU HEAR OF OUR OFFICE:

EMPLOYER INFORMATION:
TYPE OF WORK YOU DO:____
EMPLOYER: ____
EMPLOYER ADDRESS: ____
NUMBER & STREET CITY STATE ZIP

☐ Full-time ☐ Part-time ☐ Homemaker ☐ Retired ☐ Student ☐ Unemployed
☐ 0-20 hrs per week, ☐ 20 to 40 hours per week, ☐ 40 to 50 hours per week, ☐ 60 to 70 hours per week
☐ Mostly sitting, ☐ Mostly standing ☐ Mostly walking,
☐ Light labor ☐ Moderate labor ☐ Heavy labor
☐ Computer work, ☐ Repetitive activities ☐ Heavy telephone use.

____

Social Habits:

Tobacco use: ☐ light ☐ social ☐ moderate ☐ heavy ☐ non-smoker
Alcohol use: ☐ Social ☐ light ☐ moderate ☐ heavy ☐ Alcoholic ☐ Recovering Alcoholic ☐ Does not drink
Have you used recreational drugs: (M*arijuana, Crack, Cocaine, etc.*)? ☐ No use of recreational drugs
☐ Light ☐ moderate ☐ heavy ☐ drug addicted ☐ recovering drug addict

Family History:

	Mother	Father	Sister	Brother
Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐

Patient Name: ______________________________ Date: ____________ Acct. #: __________

PAST MEDICAL HISTORY:

Allergies: ____

SURGICAL HISTORY: ____

MEDICATIONS YOU ARE PRESENTLY TAKING: ____

____

Are you pregnant? ☐ Yes ☐ No

Number of children? ______ Number of pregnancies ? _______ Number of deliveries? ___________

Illnesses:

☐ Cancer	☐ Multiple sclerosis	☐ Heart problems	☐ Osteoarthritis
☐ Hypothyroidism	☐ Diabetes	☐ Asthma	☐ High Blood Pressure
☐ Hyperthyroidism	☐ Hypoglycemia	☐ Bleed easily	
☐ Migraine headaches	☐ High Cholesterol	☐ Rheumatoid arthritis	

Other conditions: ____

Accidents: Please check all that apply

☐ No previous trauma	☐ Multiple automobile accidents	☐ Multiple motorcycle accidents
☐ Previous automobile accident	☐ Multiple slip and falls	☐ Boating accident
☐ Slip and fall	☐ Motorcycle accident	☐ Multiple Boating accidents

Did any of these accidents cause a permanent injury or disability? ☐ Yes ☐ No

If yes, Please explain:____

Did any of these accidents result in hospitalization? ☐ Yes ☐ No

If yes please explain: ____

Mechanism of Injury (How did this injury happen):

No known injury	Fell	Lifting/Wrestling/ Playing with Children/Others	Reaching and pulling	Pushing
Auto accident	Lifting (Please Name) ___________	Twisted	Yardwork	Exercising
Playing sports (Please Name) ____________	Bent forward	Slipped on ice	Shoveling snow	Other: __________

Onset of Current Injury (When did this injury most recently occur):

Less than 1	Hours
1, 2, 3	Days
4, 5, 6	Weeks
7, 8, 9, 10	Months

IF this injury has occurred before, *when* was the first occurrence? _______________________________

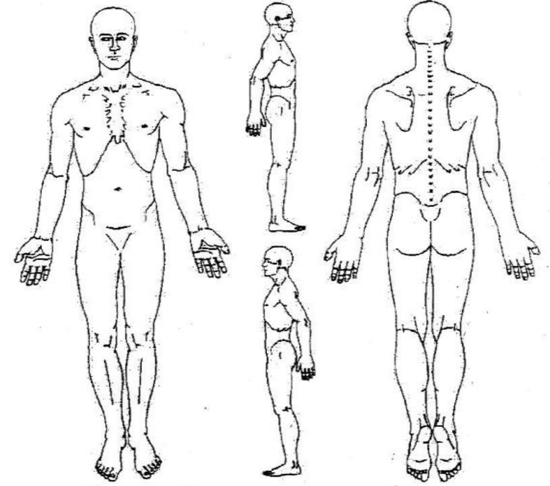
Patient Name: ______________________________ Date: ____________ Acct. #: __________

Primary Complaint: ____

Secondary Complaint: ____

Other: ____

On the diagram, please indicate where you have any complaints (Primary and secondary).



Please use the following key to mark exact locations of your pain.

P = Sharp Pain (*Default)*
D = Dull Pain
T = Tingling
N = Numbness
B = Burning
S = Stiffness
A = Achy

Please circle the severity of your symptoms on a scale of 0—10.

None 0 1 2 3 4 5 6 7 8 9 10 Extreme

HOW OFTEN does this bother you? (this occurrence only, please circle ONE):

Constant Daily 4-6x / week 1-3x / week Less than 1x / week Intermittent

IF NOT CONSTANT, HOW LONG do the symptoms last when they do bother you? (Circle the best ONE):

All Day	Several Hours	About 1 Hour	30 min	Less than 15 min
Short Spurts	Only when Active	Only at Night	Only In The Morning	Varies

Are there any *aggravating* factors? (What makes the pain worse?)

	Bending or Twisting	Exercising	Lifting more than 10 lbs
Nothing	Pulling	Reaching	Lifting more than 20 lbs
	Walking	Sitting	Lifting more than 50 lbs
	Laying Down	Standing	Other: _____________

Are there any *relieving* factors? (What helps relieve the pain?)

	Heat or Ice	Prescription Drugs	Non-Prescription Drugs
Nothing	Pillows	Rest	Laying Down
	Sitting	Sleeping	Standing
	Stretching	Support Brace	Other: _____________

Have you seen any other providers (MD, DO, DC, PT, Massage) for this injury? Yes No

If yes, please list: ____

Have there been any changes in your health history since this injury occurred? Yes No

If yes, please list: ____

REVIEW OF SYSTEMS Patient Name: ______________________________ Date: __________ Acct. #:

CONSTITUTIONAL SYMPTOMS?
☐ No symptoms
☐ Decreased activity level
☐ Fever
☐ Chills
☐ Night sweats
☐ Fatigue
☐ Loss of appetite
☐ Weight loss
☐ Weight gain
☐ Loss of energy
☐ Uncontrolled sweating.

PSYCHIATRIC SYMPTOMS?
☐ No Symptoms
☐ Irritability
☐ Depression
☐ Disturbed sleep
☐ Suicidal thoughts
☐ Anxiety
☐ Nervousness

GENITOURINAY SYMPTOMS?
☐ No symptoms
☐ Dysuria (Pain with urination)
☐ Frequent urination
☐ Urgency
☐ Losing control/incontinence
☐ Blood in urine
☐ Bowel dysfunction

ENDOCRINE SYMPTOMS?
☐ No symptoms
☐ Diabetes
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Other thyroid problems

HEAD & ENT SYMPTOMS?
☐ No symptoms
☐ Changes in head dimensions
☐ Blurred or Double vision
☐ Earaches
☐ Recent hearing loss
☐ Chronic ear infections
☐ Hoarseness
☐ Sore throat
☐ Difficulty swallowing

CARDIOVASCULAR SYMPTOMS?
☐ No symptoms
☐ Chest pain
☐ Palpations
☐ Dizziness
☐ Dyspnea (uncomfortable breathing)
☐ Hypertension (high blood pressure)
☐ Hypotension (low blood pressure)
☐ Excessive bruising
☐ Lower extremity edema

RESPIRATORY SYMPTOMS?
☐ No Symptoms
☐ Coughing
☐ Shortness of Breath
☐ Asthma
☐ Apnea
☐ Emphysema
☐ Pneumonia
☐ Wheezing

GASTROINTESTINAL SYMPTOMS
☐ No Symptoms
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Ulcer
☐ Heartburn

MUSCULOSKELETAL SYMPTOMS?
☐ No symptoms
☐ Osteoporosis
☐ Scoliosis
☐ Arthritis
☐ Neck pain
☐ Back problems
☐ Hip disorders
☐ Knee injuries
☐ Foot/Ankle pain
☐ Shoulder problems
☐ Elbow/wrist pain
☐ TMJ issues
☐ Poor posture

INTEGUMENTARY SYMPTOMS?
☐ No Symptoms
☐ Rash
☐ Easy bruising
☐ Gum bleeding
☐ Hyper/Hypo pigmentation
☐ Excessive Acne
☐ Eczema
☐ Psoriasis
☐ Skin cancer
☐ Excessive hair loss

IMMUNOLOGIC SYMPTOMS?
☐ No Symptoms
☐ Enlarged lymph nodes
☐ Hives
☐ Hay fever
☐ Persistent infections

NEUROLOGIC SYMPTOMS?
☐ No Symptoms
☐ Numbness & Tingling
☐ Seizures
☐ Abnormal sensory feelings in extremities
☐ Loss of memory
☐ Trigeminal neuralgia
☐ Neuralgia
☐ Fibromyalgia
☐ Pins and needles feeling

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon charges made for your services.

In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any company (the pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance proceeds (whether it be all or part of what is due), I personally owe you.

____________________________________ ____________

Signature Date

☐ I would prefer to have a clinical summary printed for me at each visit. I understand due to the nature of chiropractic visits this information will often times be only my name and date of service.

☐ I waive the clinical summary at each visit. I understand that I will have access to my medical record through the patient portal.