COLOR CHIROPRACTIC

PATIENT MEDICAL RECORD

Confidential information required for case history file

PATIENT: Date:______________________

Last Name:__________________________ First Name:________________________ Middle:___________

Address: ____ Apartment:_____________________

City: ____________________________________ State: _________________ Zip: ___________________

Home Phone: ______________________________ Work Phone: _________________________________

Cell Phone: ______________________________ Social Security #:_________________________________

Please include your e-mail and indicate if you would like the the following information sent to you:

E-mail Address: ____________________ E-Appointment reminder ____ Health Research Blog ____

Gender: M F Date of Birth: _____________________Age:_____ Marital Status: M S W D

Employer: _____________________________________ Occupation: ______________________________

Employer Address: ____

City: ____________________________________ State: _________________ Zip: ___________________

Whom can we thank for referred you to our office? ____

Name of Spouse ______________________ Names and Ages of Children______________________________

Have Your Children Received Previous Chiropractic Care? Y N ______________________________________

Parent's Name (if you are under 18 years of age) ____

MAJOR COMPLAINTS:

Describe your major complaint in detail: ____

____

____

Date when condition first started: ______________

Cause of pain, if known: ____

Is this condition due to an accident? Y N Date: ____

Auto: ___ Work Related: ___ Fall: ___ Other: ____

Have you been treated for this condition? Y N If yes when?____________________________________

Name of treating MD: _____________________________ What was done? _________________________

Name of other therapist assisting you with your care:____

Have you had a similar condition before? Y N If yes when? ___________________________________

Were you treated? Y N If yes by whom: ____

List all medication, vitamins, and minerals, etc. you are taking: _____________________________________

____

Please indicate where and if any x-rays/labs have been taken in the past year?________________________

____

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Which of these factors affect your condition (please check all that apply)?

	No Effect	Better	Worse		No Effect	Better	Worse
Working	❑	❑	❑	End of the day	❑	❑	❑
Sitting	❑	❑	❑	During heavy activity	❑	❑	❑
Standing	❑	❑	❑	While resting	❑	❑	❑
Walking	❑	❑	❑	Before meals	❑	❑	❑
Lying Down	❑	❑	❑	During meals	❑	❑	❑
During the night	❑	❑	❑	After meals	❑	❑	❑
First thing in morning	❑	❑	❑	Recreation/Play	❑	❑	❑

SYMPTOMS: Check the following which you have had and underline any you have now.

GASTROINTESTINAL
__Constipation
__Diarrhea
__Digestive problems
__Stomach pain
__Vomiting of blood
__Gall bladder trouble
__Hemorrhoids
__Liver trouble

SKIN
__Bruising
__Boils
__Dryness

GENITOURINARY
__Frequent urination
__Painful urination
__Difficulty starting urine
__Inability to control urine
__Blood in urine
__Bed wetting
__Kidney infection
__Prostate trouble

MUSCLES AND JOINTS
__Foot problems
__Swollen joints
__Hernia

CARDIO VASCULAR
__High blood pressure
__Low blood pressure
__Previous heart trouble
__Previous stroke

FOR WOMEN ONLY
__Cramps __Backache
__Excessive flow
__Hot flashes
__Irregular cycles
__Painful intercourse
__Painful menstruation
__Vaginal discharge

RESPIRATION
__Chest pains
__Chronic cough
__Difficulty breathing
__Frequent colds
__Spitting blood
__Allergies general
__Weight loss
__Nervousness
__Emotional issues

Date of last physical

____

EYES-EARS-NOSE
__Eye pain
__Earaches
__Ear discharge
__Ringing of ears
__Nasal discharge
__Nose bleeds
__Sinus trouble
__Difficulty swallowing
__Hoarseness
__Asthma

Date of last exam

____

WHAT ARE YOUR GOALS FOR YOUR HEALTH CHALLENGES? (Please CHECK ALL that apply):

___ pain/symptom relief ___ isolate and fix the cause of the problem ___ adopting a wellness lifestyle

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PATIENT PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching △△△

Numbness * * *

Pins & Needles ○○○

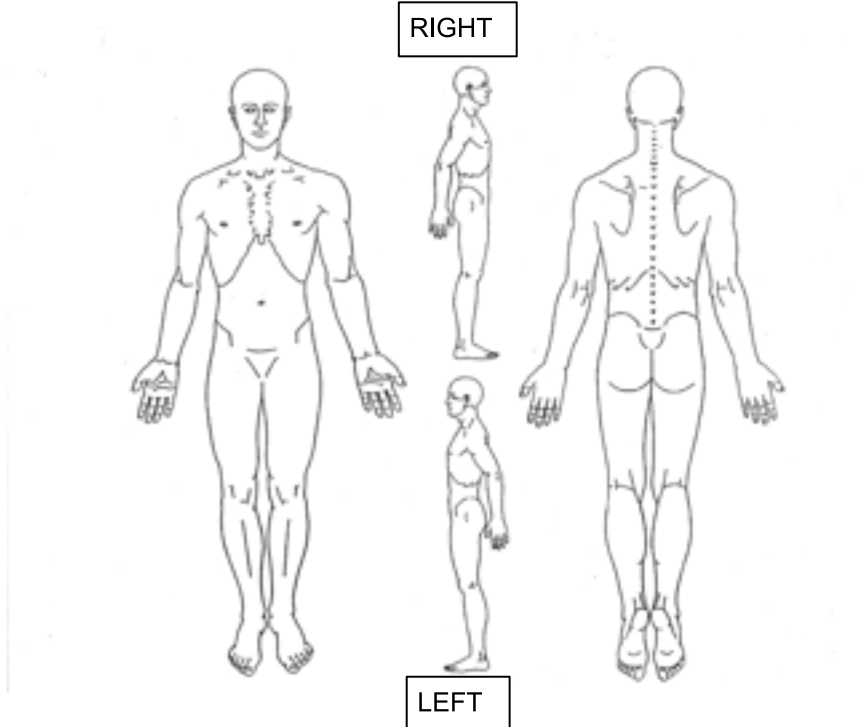
Burning X X X

Stabbing ↘↘↘

Other ○○○

Pain in arm(s)
Compared to Neck:
❑ Worse Than
❑ Same As
❑ Less Than

Pain in leg(s)
Compared to Back:
❑ Worse Than
❑ Same As
❑ Less Than



Please put a mark on the scale to show how bad your usual discomfort has been recently. If you are describing more than one symptom, indicate the level of pain for each symptom.

No discomfort — Worst Possible Discomfort

1	2	3	4	5	6	7	8	9	10

LIFESTYLE HISTORY:

What is your typical weekly exercise program?____________________

What is a typical breakfast for you? ____________________

What is a typical lunch for you?____________________

What is a typical evening meal for you?____________________

What activities do you use to relieve stress?____________________

Please list any MAJOR accidents, broken bones, spills or falls you have had (Please indicate dates):

____

____

List any type of surgeries with dates: ____________________

List any major illnesses: ____________________

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OFFICE POLICY

We want to ensure that you have a good experience with your care. Therefore, we have laid out clear expectation of office policies we strictly abide by. Please read each policy and initial next to each policy so we are aware that you have a clear understanding and will abide by the following practices. If you do not provide your initial, we will be happy to answer questions you have.

APPOINTMENT POLICY ______ (Please initial)
For your convenience, multiple appointments can be scheduled to minimize waiting. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. A 24 hour cancellation notice is required to enable us to fill the appointment time and a **$25 service fee** will be assessed for cancelled/missed appointments that are without 24 hours notice. Exceptions will naturally be given in cases of Emergency (ex. accident, death in the family, etc). We will also extend a one time warning as a courtesy to you.

CONFIDENTIALITY POLICY ______ (Please initial)
In accordance with Federal Law, HIPAA, (Health Insurance Portability and Accountability Act) you can be assured that your personal and private health information will be protected and kept private. We will not release any of your private and personal health information without your express, written consent. The information will only be released to the party which you have designated in writing and dated.

We reserve the right to contact you via mail, E-mail or phone as is necessary to remind you of upcoming/ missed appointments, upcoming events/updates on our clinic procedures, birthdays and educational opportunities. At the same time, we cannot ensure your complete privacy in situations where the contact information you provide is being used by others (Ex. reminder calls to your residence). If you would like to make special arrangements, please let us know.

FINANCIAL POLICY ______ (Please initial)
Payment is to be made at the time of services rendered. Other financial arrangements may be offered at a later time as a courtesy to help you save money on your care and reduce processing/book keeping time.

Returned checks will also be subjected to a $20 service fee and balances over 30 days may be subject to additional collection fees and interest charges of 1½ % per month. All accounts not paid within 90 days will also automatically be put through on your personal credit card:

Please be aware that if you have insurance, your insurance policies represent an arrangement between your insurance carrier and you/the person mentioned on the policy. Because insurance policies vary in terms of coverage, we will not be held responsible for the reimbursement of the care you receive. We will prepare the necessary documents for you, but this may not ensure full reimbursement. Please also be aware that If insurance companies require an extended narrative for reimbursement, we will make you aware and an additional charge to you may be necessary if you would like to proceed with reimbursement.

Please know that our loyalty comes in our commitment to your health. By signing your signature below, you are in full agreement with the policies outlined above.

SIGNATURE: ______________________________ DATE: ______________________________