

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
<u>Working</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>End of the day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Sitting</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>During heavy activity</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Standing</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>While resting</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Walking</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Before meals</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Lying Down</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>During meals</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>During the night</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>After meals</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>First thing in morning</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Recreation/Play</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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):

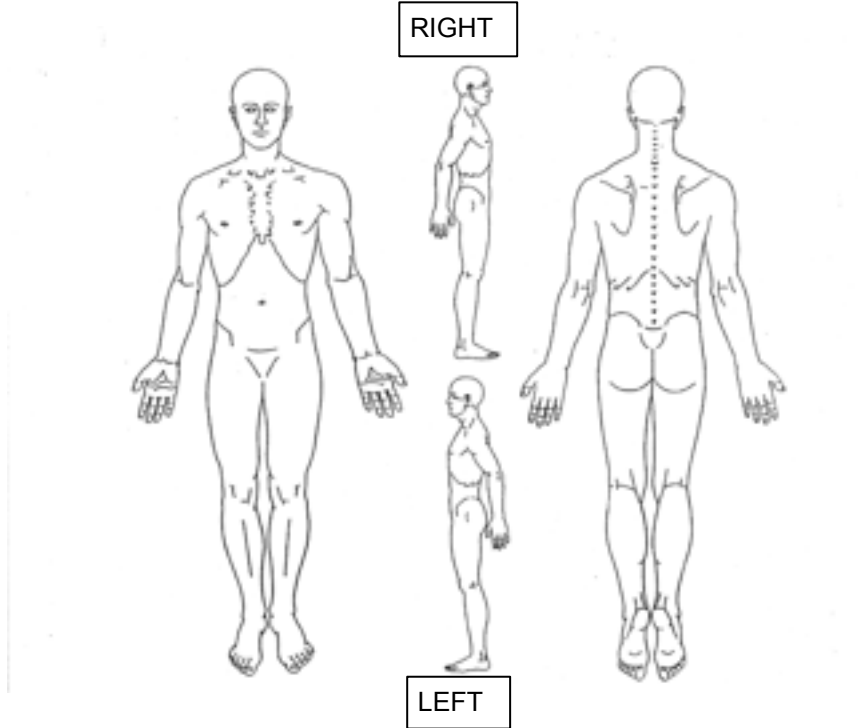
- pain/symptom relief isolate and fix the cause of the problem adopting a wellness lifestyle

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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 XXX
- 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 **\$27 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: _____