SHAPIRO HOLISTIC HEALTH & CHIROPRACTIC

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Confidential Patient Health Record

Date: _____

Patient Information:

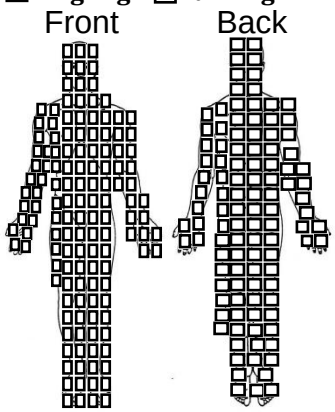
Name: _____ Birth Date: _____ Phone: _____
Work Phone:_____Cell Phone:_____
Gender:☐**M**☐**F** Race: _____ Ethnicity:☐**Hispanic/Latino**☐**Not Hispanic/Latino**

Preferred Language: _____ Address: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ Email: _____
Employment Status☐**Working**☐**Retired**☐**Unemployed**☐**Part--Time Student**☐**Full--Time Student**
Occupation: _____ Employer: _____
Marital Status:☐**Single**☐**Married**☐**Partnered**☐**Widowed**☐**Divorced**☐**Separated**
Spouse's Name: _____ Occupation: _____
Spouse Cell#_____Spouse_Employer:_____
Personal Health Insurance Carrier: _____
Insured Person's Name: _____ID_Number:_____
DOB of Insured: _____ Insured's Social Security #:_____
Name of Previous Chiropractor: _____
Name of Medical Doctor: _____
Referred To This Office By:☐**Print Ad**☐**Mailing**☐**Search Engine**☐**Internet Offer**☐**Other:** _____
Name and Number of Emergency Contact: _____

Patient Condition:

Reason(s) for visit:_____
Is this condition due to an accident?☐**YES** /☐**NO** ☐**Auto**☐**Work**☐**Home**☐**Other** Date:_____
When did your symptoms appear?_____ Is this condition getting worse?☐**YES** /☐**NO**
Is it constant or does it come and go? _____Is it worse with rest or activity? _____
What do you think caused this problem? _____
Which best describes the character of your pain?☐**Dull/Ache**☐**Sharp** ☐**Numb** ☐**Tingling** ☐**Burning**
Is the pain worse in the AM or PM? _____
What treatments have you already received for your condition?
☐**None** ☐**Physical Therapy** ☐**Massage Therapy** ☐**Medications**
☐**Surgery** ☐**Chiropractic** ☐**Other:** _____
What activities are difficult/painful to perform?
☐**Sit** ☐**Stand** ☐**Sit to Stand** ☐**Walk** ☐**Bend** ☐**Drive**
☐**Computer Work**☐**Lay Down**☐**Sleep**☐**Other:**_____
What is your pain intensity on a scale of 1 to 10? (1 = mild, 10 = disabled)

1-2-3-4-5-6-7-8-9-10
☐☐☐☐☐☐☐☐☐☐
Mark an "**X**" on the picture where you are experiencing symptoms:



Personal Health History:

Date of Last: Spinal X-Ray _____ MRI _____ CT-Scan _____ Blood Test _____
Colonoscopy _____ Prostate/PSA _____ Pap Smear _____ Mammogram _____

Have you had any surgeries? _____
What medications are you currently taking, dosages, and for what condition(s)? _____
_____
_____
_____

Do you have any allergies? ☐ **YES** / ☐ **NO** List: _____
What vitamins/supplements are you currently taking? _____
_____

Are you pregnant? ☐ **YES** / ☐ **NO** Due Date: _____

Please circle to indicate if you have experienced any of the following:

☐ Headaches	☐ Frequent colds	☐ Menstrual problems	☐ Concussion
☐ Migraines	☐ Thyroid problems	☐ Difficulty getting pregnant	☐ Dislocation
☐ Sinus Problems	☐ Throat problems	☐ Vascular problems	☐ Fracture
☐ Dizziness	☐ Asthma	☐ Digestive problems	☐ Leg pain
☐ Vertigo	☐ Difficulty breathing	☐ Alzheimer's	☐ Hip pain
☐ Nausea	☐ Chest pains	☐ Memory loss	☐ Wrist/hand pain
☐ Earaches	☐ Stroke	☐ Insomnia	☐ Ankle pain
☐ Ringing in ears	☐ Poor circulation	☐ Cancer	☐ Foot pain
☐ Difficulty hearing	☐ Heart problems	☐ Diabetes	☐ Shoulder pain
☐ Vision problems	☐ Skin problems	☐ Hypertension	☐ Low back pain
☐ Nose bleeds	☐ Easy bruising	☐ Hypoglycemia	☐ Mid back pain
☐ Anxiety	☐ Liver problems	☐ Chronic cough	☐ Neck pain
☐ Depression	☐ Kidney problems	☐ Arthritis	☐ Other joint pain
☐ Nervousness	☐ Fatigue	☐ Scoliosis	☐ Prostate problems

Other, please specify: _____
_____
_____

Family Health History:

Relation	**Living**	**Deceased**	**Age (now or at death)**	**Illness/Cause of Death**
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

Social/Work History:

Work Activity: ☐**Sit** ☐**Stand** ☐**Computer Work** ☐**Light Labor** ☐**Heavy Labor**

Diet/Nutrition: Are you on any special diet? ☐**YES** /☐**NO** If yes, for what reason? _____
Have you gained or lost over 10 pounds in the past 6 months without wanting to? ☐**YES** ☐**NO**

How many 8 ounce glasses of the following to you drink per day?
Water: _____ Soda: _____ Coffee: _____ Tea: _____ Energy Drinks: _____

Is your current weight a concern to you? ☐**YES** ☐**NO**

Habits: Tobacco Use: Now? ☐**YES** ☐**NO** Amount/Weekly_____How long?_____Years/Months
In the past? ☐**YES** /☐**NO** Amount/Weekly_____ How long?_____Years/Months

Alcohol Use: Now? ☐**YES** /☐**NO** Amount/Weekly_____How long?_____Years/Months
In the past? ☐**YES** /☐**NO** Amount/Weekly_____How long?_____Years/Months

Review: **Rate each of these areas on a scale of 0 to 10** (0= Best - 10= Worse)

Stress Level	No Stress	☺ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹	Very Stressed
Exercise	High Intensity	☺ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹	No Exercise
Daily Activity	Normal	☺ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹	Stuck In Bed
Sleep	Fully Rested	☺ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹	No Sleep
Appetite	Normal	☺ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹	Eat Nothing
Mood	Happy, Relaxed	☺ ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☹	Depressed

While we will work closely with you to resolve your chief complaint, as health care professionals we are also concerned about your overall wellness. On future visits we will/may discuss issues that might impact your overall health.

All of the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Shapiro Holistic Health & Chiropractic at this time:

_____

Patient's Signature **Date**

_____

Signature of Parent or Legal Guardian **Date**