Confidential Patient Health Record

***Today's Date*:**___/____/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Title: ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.**

Last:_____ **First:**_____ **Middle:** _____

Suffix: ☐ **Jr** ☐ **Sr** ☐ **II** ☐ **III**

Birth Date: ____/____/_____ **Age:**_____ **Sex: Male / Female SSN:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Address: _____**Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Home Phone: (_____**)** _____**-**_____ **ext** _____ **Work Phone: (**_____**)** _____**-**_____ **ext** _____

Cell Phone: (_____**)** _____**-**_____ **ext** _____ **Fax #: (**_____**)** _____**-**_____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ **First:**_____**Middle:**_____

Relationship: ☐ **Spouse** ☐ **Relative** ☐ **Friend** ☐ **Other** _____

Home Phone: (_____**)** _____**-**_____ **ext** _____ **Cell Phone: (**_____**)** _____**-**_____ **ext** ___

Work Phone: (_____**)** _____**-**_____ **ext** _____

Employment Information

Business Name: _____

Phone: (_____**)** _____**-**_____ **Fax #: (**_____**)** _____**-**_____

Employer's Email Address: _____

Occupation/Job Title: _____ **Job Description** _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

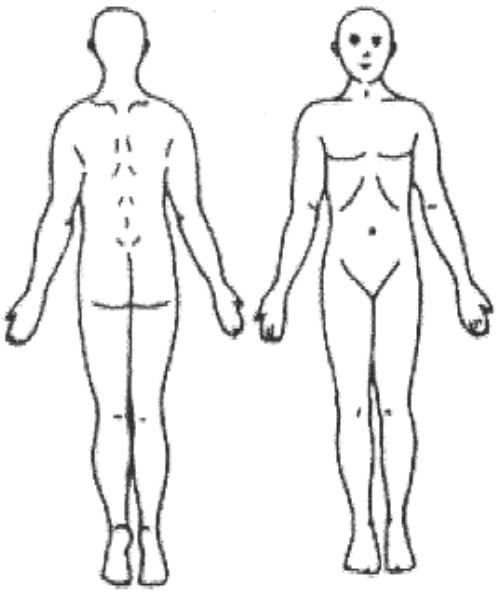
Patient Name: _____ Date:_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** _____

Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: _____

_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ chills	☐ fatigue	☐ night sweats	☐ weight loss
☐ daytime drowsiness	☐ fever	☐ weight gain	

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ blindness	☐ change in vision	☐ field cuts	☐ photophobia
☐ blurred vision	☐ double vision	☐ glaucoma	☐ tearing
☐ cataracts	☐ eye pain	☐ itching	☐ wear glasses/contacts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ bleeding	☐ ear drainage	☐ hearing loss	☐ nosebleeds	☐ sore throat
☐ dentures	☐ ear pain	☐ history of head injury	☐ postnasal drip	☐ tinnitus (ringing in ears)
☐ difficulty swallowing	☐ fainting	☐ hoarseness	☐ rhinorrhea (runny nose)	☐ TMJ problems
☐ discharge	☐ frequent sore throats	☐ loss of sense of smell	☐ sinus infections	
☐ dizziness	☐ headaches	☐ nasal congestion	☐ snoring	

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ asthma	☐ coughing up blood	☐ sputum production
☐ cough	☐ shortness of breath	☐ wheezing

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Phone: 623-252-1512 ▪ Fax: 623-334-0182

Patient Name: _____ Date:_____

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ angina (chest pain or discomfort)	☐ high blood pressure	☐ shortness of breath with exertion or exercise
☐ chest pain	☐ low blood pressure	☐ swelling of legs
☐ claudication (leg pain/ache)	☐ orthopnea (difficulty breathing lying down)	☐ ulcers
☐ heart murmur	☐ palpitations	☐ varicose veins
☐ heart problems	☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)	

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain	☐ diarrhea	☐ indigestion	☐ abnormal stool caliber	☐ vomiting blood
☐ belching	☐ difficulty swallowing	☐ jaundice	☐ abnormal stool color	
☐ black - tarry stools	☐ heartburn	☐ nausea	☐ abnormal stool consistency	
☐ constipation	☐ hemorrhoids	☐ rectal bleeding	☐ vomiting	

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal bleeding
☐ breast lumps/pain	☐ frequent urination	☐ pregnancy	☐ vaginal discharge
☐ burning urination	☐ hormone therapy	☐ urine retention	

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination	☐ frequent urination	☐ prostate problems
☐ erectile dysfunction	☐ hesitancy/ dribbling	☐ urine retention

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ cold intolerance	☐ excessive hunger	☐ goiter	☐ unusual hair growth
☐ diabetes	☐ excessive thirst	☐ hair loss	☐ voice changes
☐ excessive appetite	☐ abnormal frequency of urination	☐ heat intolerance	

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture	☐ hair loss	☐ itching	☐ skin lesions / ulcers
☐ changes in skin color	☐ hives	☐ paresthesias	☐ varicosities
☐ hair growth	☐ history of skin disorders	☐ rash	

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness	☐ limb weakness	☐ numbness	☐ slurred speech	☐ tremor
☐ facial weakness	☐ loss of consciousness	☐ seizures	☐ stress	☐ unsteadiness of gait/ loss of balance
☐ headache	☐ loss of memory	☐ sleep disturbance	☐ strokes	

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia	☐ behavioral change	☐ convulsions	☐ memory loss
☐ anxiety	☐ bi-polar disorder	☐ depression	☐ mood change
☐ loss or change in appetite	☐ confusion	☐ insomnia	

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphalaxis	☐ itching	☐ chronic nasal congestion	☐ sneezing
☐ food intolerance	☐ acute nasal congestion	☐ rash	

Hematologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia	☐ blood clotting	☐ bruising easily	☐ lymph node swelling
☐ bleeding	☐ blood transfusion	☐ fatigue	

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PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:
☐ I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____
Type of Treatment: _____ Was the treatment beneficial in resolving condition? ☐ Yes ☐ No

Explain: _____

Previous Chiropractic Care: **☐ I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- ☐ ADD
- ☐ atopic dermatitis (eczema)
- ☐ allergies/hayfever
- ☐ anemia
- ☐ asthma
- ☐ bedwetting
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ depression
- ☐ diabetes
- ☐ ear infections
- ☐ fetal drug exposure
- ☐ food allergies (list below)
- ☐ headaches
- ☐ hepatitis
- ☐ HIV
- ☐ measles
- ☐ mumps
- ☐ psoriasis
- ☐ rash
- ☐ scoliosis
- ☐ seizure disorder
- ☐ sickle cell anemia
- ☐ spina bifida
- ☐ other:

Adult Illness(es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

- ☐ ADD
- ☐ alzheimers
- ☐ anemia
- ☐ arthritis
- ☐ asthma
- ☐ cancer
- ☐ cerebral palsy
- ☐ chicken pox
- ☐ crohn's/colitis
- ☐ CRPS (RSD)
- ☐ CVA (stroke)
- ☐ cystic kidney disease
- ☐ depression
- ☐ diabetes (insulin dep)
- ☐ diabetes (non insulin)
- ☐ eczema
- ☐ emphysema
- ☐ eye problems
- ☐ fibromyalgia
- ☐ heart disease
- ☐ hepatitis
- ☐ HIV
- ☐ hypertension
- ☐ influenzal pneumonia
- ☐ liver disease
- ☐ lung disease
- ☐ lupus erythema (discoid)
- ☐ lupus erythema (systemic)
- ☐ multiple sclerosis
- ☐ parkinson's disease
- ☐ unspecified pleural effusion
- ☐ pneumonia
- ☐ psoriasis
- ☐ psychiatric problems
- ☐ scoliosis
- ☐ seizures
- ☐ shingles
- ☐ past history of similar symptoms
- ☐ STD's (unspecified)
- ☐ suicide attempt(s)
- ☐ thyroid problems
- ☐ vertigo
- ☐ other:

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

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Patient Name: _____ Date:_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

☐ back injury	☐ head injury (loss of consciousness)	☐ motor vehicle accident
☐ broken bones	☐ head injury (no loss of consciousness)	☐ soft tissue injury (mild)
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury (moderate)
☐ fall (severe)	☐ joint injury	☐ soft tissue injury (severe)
☐ fracture	☐ laceration (severe)	☐ other:

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

general family	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____
sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____

Your Doctors:

Dr. Carranza feels that it is very important to keep your doctor(s) up to date with your treatment and progress at his office. Please fill in <u>any</u> and <u>all</u> information below.

General Physician: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

OB/Gnecologist: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

Podiatrist: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

OB/Gnecologist: _____
Address: _____
City / State / Zip: _____
Phone Number: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____

Patient's Signature: _____ **Date:** _____

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Auto Accident Form (Only if Applicable)

Patient Name _____ Today's Date ____/_____/_____

Please mark your involvement in the Auto Accident: ☐ Pedestrian ☐ Driver ☐ Passenger

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ____/_____/_____

Patient was located: ☐ Driver ☐ Passenger- middle front ☐ Passenger- right front
☐ Passenger- left rear ☐ Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Second Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Third Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Weather Conditions: ☐ Clear ☐ Cloudy ☐ Dark ☐ Foggy ☐ Icy ☐ Snowy

Were you aware the accident was going to occur? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Type of seatbelt? ☐ Lap belt only ☐ Lap and shoulder harness

Did your airbag deploy? ☐ Yes ☐ No

If yes, was there impact with airbag? ☐ Yes ☐ No ☐ Front Impact ☐ Side Impact

Does your car have a head rest? ☐ Yes ☐ No

What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Collision Details

First Impact:	☐ hit by other vehicle	☐ hit other vehicle	☐ hit by object	☐ hit object
Impact Location:	☐ front	☐ front-right	☐ front-left	☐ left
☐ right	☐ right-rear	☐ left-rear	☐ rear	☐ top
Second Impact:	☐ hit by other vehicle	☐ hit other vehicle	☐ hit by object	☐ hit object
Impact Location:	☐ front	☐ front-right	☐ front-left	☐ left
☐ right	☐ right-rear	☐ left-rear	☐ rear	☐ top

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Auto Accident Form (Only if Applicable)

Patient Name _____ Today's Date ____/_____/_____

Collision Results

Body was thrown: ☐ Forward ☐ Backward ☐ Left ☐ Right ☐ Can't Remember

Head Hit: ☐ airbag ☐ front windshield ☐ rearview mirror ☐ steering wheel
☐ dashboard ☐ back of the front seat ☐ side window/door ☐ another person's body ☐ headrest

Chest Hit: ☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ side window/door ☐ another person's body

Shoulders Hit: ☐ shoulder harness ☐ side window/door ☐ back of front seat ☐ another person's body

Knees Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Hips Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Vehicle Damage

Patient Vehicle:	**☐ totaled**	**☐ significant damage**	**☐ light damage**	**☐ no damage**
Second Vehicle:	**☐ totaled**	**☐ significant damage**	**☐ light damage**	**☐ no damage**
Third Vehicle:	**☐ totaled**	**☐ significant damage**	**☐ light damage**	**☐ no damage**

Emergency Room

Did you see any of the following? ___ Emergency Room ___Urgent Care ____Other ____ I didn't see any

Facility name: _____ Location: _____

When were you taken to? ☐ immediately ☐ later same day ☐ next day ☐ date _____

How were you transported to the ER? ☐ ambulance ☐ life flight ☐ private transportation

What did the ER recommend? ☐ no instructions ☐ see this clinic ☐ see DC
☐ see own doctor ☐ see orthopedist ☐ see neurologist ☐ prescription medication
☐ other: _____

Did you have any x-rays taken? ☐ Yes ☐ No

If yes, what areas? _____

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