

Confidential Health Record

Today's Date: ____/____/____

WELCOME TO OUR OFFICE!

Whom may we thank for referring you to our office?

Family _____ Friend _____ Co-Worker _____

Close to home/work Dr. Arbeitman Dr. _____ NUCCA Internet/Website Other _____

Personal Information

Last: _____ First: _____ Middle: _____

Birth Date: ____/____/____ Age: _____ Sex: Male / Female Social Security #: _____ - _____ - _____

Marital Status: Single Married Widowed Divorced Separated Spouses Name: _____

Address: _____ Apt # _____ Home Phone: (____) _____ - _____

City: _____ State: _____ Zip: _____ Cell Phone: (____) _____ - _____

Email Address: _____ Work Phone: (____) _____ - _____

Emergency Contact

Last: _____ First: _____

Relationship: Spouse Relative Friend Home Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Employment Information

Business Name: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____ - _____

Current Health Challenge (If you have no symptoms or complaints, and are here for "CHIROPRACTIC WELLNESS SERVICES", check here ____ and please skip to Past Health History.

Unwanted Health Challenge (Why you are here today?) PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

When did this BEGIN? ____/____/____

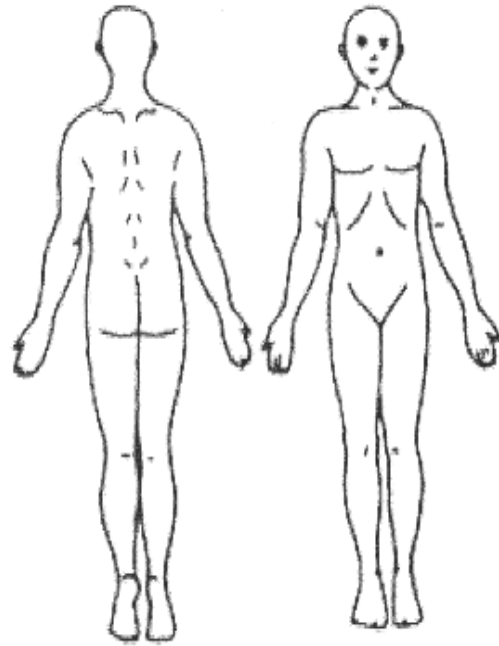
Has it ever occurred before? Yes No.

Is this related to: Auto Related Job Related Home Injury

Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Auto Crash or Work Related Injury: ____/____/____



LIFESTYLE REVIEW

1) Do you believe that it is possible for your body to heal? Yes No.

2) Have you received chiropractic services in the past? Yes No.

3) What Wellness services/products do you currently incorporate into your lifestyle? _____

4) On a scale of 1-10 describe your stress level: (1 = none/10 = Extreme)

Occupational _____ Personal _____

5) On a scale of Poor, Good, Excellent please describe your lifestyle:

Diet _____ Exercise _____ Sleep _____

General Health _____

REVIEW OF SYSTEMS -Please check the boxes below that apply to you. If none of them apply, please check the I DENY box in the shaded area.

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

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> limb weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures | <input type="checkbox"/> stress | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of memory | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |

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

- | | | | |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> fever | <input type="checkbox"/> weight gain | |

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

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |

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

- | | | |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> swelling of legs |
| <input type="checkbox"/> claudication (leg pain/ache) | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> varicose veins |

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

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

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

- | | | | |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Irritability | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion | <input type="checkbox"/> insomnia | |

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

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

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

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

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

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

Doctor's Name: _____

Childhood Illness (es): LIST all health conditions.

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions.

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

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

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> back injury | <input type="checkbox"/> broken bones | <input type="checkbox"/> fall (severe) | <input type="checkbox"/> fracture |
| <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> head injury | <input type="checkbox"/> joint injury | <input type="checkbox"/> disability |
| <input type="checkbox"/> motor vehicular crash | <input type="checkbox"/> laceration (severe) | | |

Social History: Mark all that apply below.

Tobacco: Do not use tobacco Smoke/chew ___/Day Live with a smoker Quit smoking

Alcohol: Do not use alcohol ___ Drinks/Week ___ Drinks/Month

The Statement made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature _____ Date _____