Confidential Patient Health Record

Today's Date ___/___/____

How Did You Hear About Us? ☐ Family/Friend – Name: _____ ☐ Internet
☐ The Gym ☐ Drove by ☐ Insurance Plan ☐ Other

First: _____ Middle: _____ Last: _____ Sex: M/F

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____–_____

Cell Phone Carrier: _____

Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Birth Date: ___/____/_____ Age: _____

Social Security#: _____-_____-_____

EMERGENCY CONTACT

Name: _____ Phone: (_____) _____-_____

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

EMPLOYMENT INFORMATION

Business Name: _____ Phone: (_____) _____-_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Hurley Chiropractic will prepare any necessary reports and forms to assist me in collecting payment from the insurance company, and that any further amount authorized to be paid will be paid directly to Hurley Chiropractic, and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorized the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care. I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor, for X-Rays, is for examination only and the X-ray negative will remain on the property of this office, being filed where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient (Print Name): _____ Patient Signature: _____ Date: _____

Consent to treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

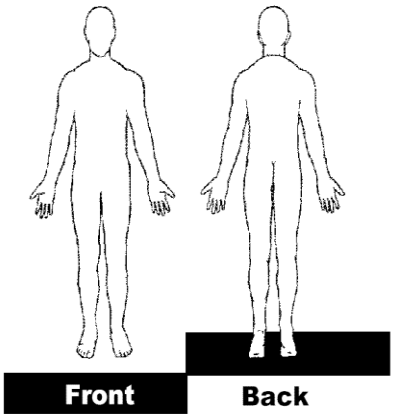
I Acknowledge That I Have Received the Chiropractic Clinic's Notice of Privacy Practices for Protected Health Information.

Patient (Print Name): _____ Date: _____

Patient's Signature: _____ Date: _____

HISTORY OF PRESENT ILLNESS

MARK DIAGRAM WITH AN X



Where is your pain the WORST? (Check Which Applies)

☐Neck ☐Mid-Back ☐Low Back ☐Shoulder ☐Elbow ☐Hip ☐Knee ☐Foot

Level of Discomfort RIGHT NOW? 0 1 2 3 4 5 6 7 8

What is the frequency of your discomfort? 10% 20% 30% 40% 50%
60% 70% 80% 90% 100%

How bad is your pain at its WORST? 0 1 2 3 4 5 6 7 8

How bad is your pain at its BEST? 0 1 2 3 4 5 6 7 8

Did your pain come on ☐Gradually ☐Suddenly?

WHAT DAY did your pain begin? _____ HOW did your pain start? _____

Since the pain/discomfort has begun, is your pain: Worse the Same Better

What makes your pain worse? (CIRCLE ALL THAT APPLY)

Walking	Sitting	Lifting	Athletic Activities	Household Chores	Personal Care
Running	Driving	Working	Standing	Changing Positions (Sit to Stand)	
Bending	Sleeping	Computer Use	(Add your own) _____		

What relieves the pain? Even if it is only temporary relief. (CIRCLE ALL THAT APPLY)

Nothing Helps	Activity	Bending	Apply Cold	Apply Heat
Massage	Movement	OTC Medicine	RX Medicine	Rest
Stretching	Sitting	Standing	Twisting	Walking

Describe your Pain? (CIRCLE ALL THAT APPLY)

Dull Aching Burning Sharp Shooting Pressure Tingling Throbbing Tightness

When is the pain at its worse? (**CIRCLE ONLY ONE**)

Morning Afternoon Evening With Activity Sleeping At Rest All the Time

Does the pain radiate into the arms or legs (CIRCLE ONE)? YES / NO If so, RIGHT / LEFT

Have you had this type of pain before? Yes No

Have you had treatment in the past? Yes No Did it help? Yes No

Since the start of your pain, has there been any changes in your bowel or bladder function? Yes No

Name: _____ Date: _____

REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these must be answered carefully as they may affect your overall course of care.

General Symptoms ☐ CHECK THIS BOX IF YOU DO NOT HAVE ANY OF THE FOLLOWING

☐ Depression ☐ Dizziness ☐ Weight Gain ☐ Diabetes ☐ Loss of Sleep
☐ Stress ☐ Headache ☐ Weight Loss ☐ Stroke ☐ Other _____

Genitourinary ☐ CHECK THIS BOX IF YOU DO NOT HAVE ANY OF THE FOLLOWING

☐ Blood in Urine ☐ Frequent Urination ☐ Lack of Bladder Control ☐ Painful Urination

Eyes, Ears, Nose, & Throat ☐ CHECK THIS BOX IF YOU DO NOT HAVE ANY OF THE FOLLOWING

☐ Blurred Vision ☐ Difficulty Swallowing ☐ Persistent Cough ☐ Earache
☐ Ringing in Ears ☐ Sinus Problems ☐ Visual Disturbances ☐ Contacts/Glasses

Muscle, Joint, Bone ☐ CHECK THIS BOX IF YOU DO NOT HAVE ANY OF THE FOLLOWING

☐ Neck Pain ☐ Muscle Spasms ☐ Arm Pain ☐ Hip Pain
☐ Mid-Back Pain ☐ Numbness/Tingling ☐ Shoulder Pain ☐ Knee Pain
☐ Low Back Pain ☐ Limb Weakness ☐ Wrist Pain ☐ Foot/Ankle Pain

Cardiovascular ☐ CHECK THIS BOX IF YOU DO NOT HAVE ANY OF THE FOLLOWING

☐ Chest Pain ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Irregular Heart Beat
☐ Swelling of Ankles ☐ Varicose Veins ☐ Heart Problems ☐ Pacemaker

Do you have any allergies? ☐ YES ☐ NO

If yes, Please List:

_____ _____ _____ _____ _____

Current Medications: List ALL medications you are CURRENTLY taking. ☐ NONE

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Surgeries: List Surgery & Approximate Date of Procedure ☐ NONE

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Current Occupation: _____ Does pain get worse with working? YES / No

NAME: _____ DATE: _____