

CONFIDENTIAL PATIENT HEALTH RECORD

Date: ___/___/___

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ___/___/___ Age: ___
First: ___ Middle: ___ Last: ___ Gender: Male / Female
Address: ___ Apt # ___
City: ___ State: ___ Zip: ___ County: ___ Country: ___
Home Phone: (____)____-____ Cell Phone: (____)____-____
Social Security #: ____-____-____ Fax #: (____)____-____
Driver's License #: ___ State: ___ Email Address: _____
Spouses Name: _____ (email address will be used for a monthly newsletter)
Ages of Children: _____

Employer

Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (____)____-____ Type of Work: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Phone Number: (____)____-____
Address: _____
Relationship: _____

Who Is Responsible For Your Bill?

Self Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ Primary Care Physician: _____
Insured Person's Social Security #: ____-____-____ Pharmacy: _____

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

Use the letters below to indicate the type and location of your sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ___/___/___

Has it ever occurred before? Yes No

When? _____

Is the condition: Auto Related Work Related

No Injury Other

Explain: _____

Date of Accident: _____

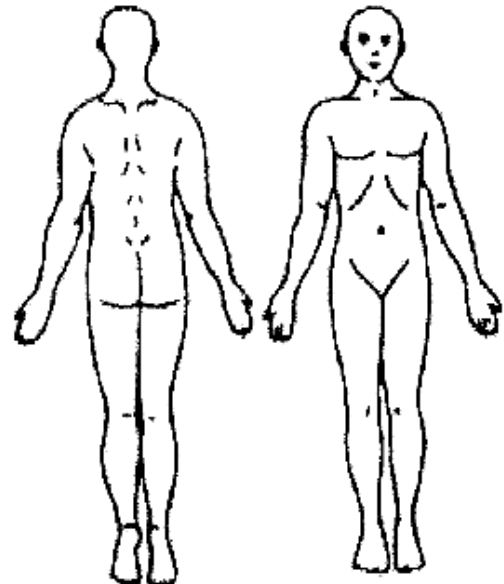
Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work Related:

Have you filed an injury report with your employer? Yes No

Claim #: _____



CHIEF COMPLAINT – HPI (HISTORY OF PRESENT ILLNESS)

Patient Name: _____ Date: _____

Chief Complaint: _____

Body Area(s) Involved: Cervical Spine, Ribs, Pelvis Upper Extremity Lower Extremity

Condition: New Recurring Exacerbation Chronic

Mechanism of Onset:

- Auto (see accident history form)
- Work... Fall Lifting Overexertion Repetitive Motion Other (see accident history form)
- Other... Etiology Unknown Overexertion Repetitive Use Slept Wrong Slip or Fall
- No Injury (see below)

Symptoms: Pain Numbness Stiffness Weakness

Location: Left /Right /Bilateral _____

Quality: Burning Diffuse Dull/Aching Localized Sharp Shooting Stabbing
 Throbbing Tightness Tingling Radiating Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Symptom(s)Started:_____ Symptom(s) Worsened:_____ Symptom(s)Last Occurred:_____
Symptom(s)Last Episode:_____ Injury Occurred:_____ Accident Occurred:_____

Timing: Worse in the: Morning Afternoon Night With Activity Constant Intermittent

Context: Better with: Warm Temp Cold Temp Worse with: Warm Temp Cold Temp Damp

Assoc Signs and Symptoms: Blurred Vision Depression Dizziness Headaches (see below)
 Irritability/Mood Swing Localized Tingling Nausea Ringing in Ears Stiffness

Headaches: (continued) Location: Occipital Frontal Temporal Parietal Sinus
Quality: Dull Sharp Throbbing Stabbing Aura No Aura
Types: Hat Band Cluster Migraine Tension

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms: Aches Cold Limb Dizziness Ecchymosis
 Fatigue Fever Heartburn Muscle Spasm Nausea Numbness
 Pale Bluish Skin Panic Pins & Needles Runny Nose SOB Stiffness
 Sweating Swelling Tingling Vomiting Weakness

Modifying Factors:

Symptoms Better With: Activity Bending Cold Heat Massage
 Movement OTC Meds Rx Meds Rest Stretching Sitting
 Standing Twisting Walking Nothing Helps

Symptoms Worse With: _____

Have you seen other doctors for this condition? Yes No If yes, Who? (Name) _____

Location of Office: _____ Type of Treatment: _____

Were you satisfied with the results of your treatment? Yes No Explain: _____

Are you currently taking any prescription medications? Yes No. If yes, please mark or list below (be specific).

- Allergy Medication Anti-Depressants Blood Pressure Medication Insulin Muscle Relaxers
 Nerve Pills Pain Killers Other (please be specific): _____

Do you wear any of the following? Yes No. If yes, please mark: Heel Lifts Innersoles Arch Supports Orthotics

Since condition began, has anything permanently helped you? YES NO

Has anything that you have done, thus far, fixed you problem? YES NO

Please list any other conditions you feel we should know about – even if unrelated: _____

REVIEW OF SYSTEMS - Below is a list of diseases 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.

- Please fill out all of the sections, even if “DENY”.

Constitutional:

I... Deny Any Constitutional Issue (s)

- Chills Daytime Somnolence (Drowsiness) Fatigue Fever Night Sweats
 Weight Gain Weight Loss

Eyes/Vision:

I... Deny Any Eyes/Vision Issue (s)

- Blindness Blurred Vision Cataracts Change in vision Double Vision
 Eye Pain Field Cuts (visual field defect) Glaucoma Itching (around the eyes) Photophobia
 Tearing Wears Glasses and/or Contact lenses

Ears, Nose and Throat:

I... Deny Any Ears, Nose and Throat Issue (s)

- Bleeding Dental Implants Dentures Difficulty Swallowing Discharge
 Dizziness Ear Drainage Ear Infection(s) Ear Pain Fainting
 Headaches Head Injury (history of) Hearing Loss Hoarseness Loss of Smell
 Nasal Congestion Nose bleeds (frequent) Post Nasal Drip Rhinorrhea (Runny nose) Sinus Infections
 Snoring Sore Throats (frequent) Tinnitus (Ringing in Ears) TMJ problems

Respiration:

I... Deny Any Respiratory Issue (s)

- Asthma Cough Coughing up blood Shortness of Breath Sputum Production Wheezing

Cardiovascular:

I... Deny Any Cardiovascular Issue (s)

- Angina (chest pain or discomfort) Chest Pain Claudication (leg pain or achiness) Heart Murmur
 Heart Problems Orthopnea (difficulty breathing while lying down) Palpitations (irregular or forceful beating of the heart)
 Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) Shortness of Breath with Exertion or Exercise
 Swelling of Legs Ulcers Varicose Veins

Gastrointestinal:

I... Deny Any Gastrointestinal Issue (s)

- Abdominal Pain Belching Black, Tarry Stools Constipation Diarrhea
 Difficulty Swallowing Heartburn Hemorrhoids Indigestion Jaundice (yellowing of the skin)
 Nausea Rectal Bleeding Abnormal Stool Caliber (quality) Abnormal Stool Color
 Abnormal Stool Consistency Vomiting Vomiting Blood

Female:

I... Deny Any Female Issue (s)

- Birth Control Therapy Breast Lumps/Pain Burning Urination Cramps Frequent Urination
 Hormone Therapy Irregular Menstruation Urine Retention Vaginal Bleeding Vaginal Discharge

Male:

I... Deny Any Male Issue (s)

- Burning Urination
- Urine Retention
- Erectile Dysfunction
- Frequent Urination
- Hesitancy/Dribbling
- Prostate Problems

Endocrine:

I... Deny Any Endocrine Issue (s)

- Cold Intolerance
- Frequent Urination
- Voice Changes
- Diabetes
- Goiter
- Excessive Appetite
- Hair Loss
- Excessive Hunger
- Heat Intolerance
- Excessive Thirst
- Unusual Hair Growth

Skin:

I... Deny Any Skin Issue (s)

- Changes in Nail Texture
- Paresthesia (numbness, prickling, or tingling)
- Changes in Skin Color
- Rash
- Hair Growth
- History of Skin Disorders
- Hair Loss
- Skin Lesions/Ulcers
- Hives
- Itching
- Varicosities

Nervous System:

I... Deny Any Nervous System Issue (s)

- Dizziness
- Loss of Memory
- Stress
- Facial Weakness
- Numbness
- Strokes
- Headaches
- Seizures
- Tremors
- Limb Weakness
- Sleep Disturbance
- Unsteadiness of Gait
- Loss of Consciousness
- Slurred Speech

Psychological:

I... Deny Any Psychological Issue (s)

- Anhedonia (inability to experience joy or enjoy life)
- Bipolar Disorder
- Mood Change(s)
- Anxiety
- Confusion
- Convulsions
- Depression
- Appetite Changes
- Insomnia
- Behavioral Change(s)
- Memory Loss

Allergy:

I... Deny Any Allergy Issue (s)

- Anaphylaxis (history of)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:

I... Deny Any Hematological Issue (s)

- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

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

Childhood Illness:

I... Deny Any Childhood Illness (es)

- ADD
- Cerebral Palsy
- Fetal Drug Exposure
- Measles
- Sickle Cell Anemia
- Allergies/Hay fever
- Chicken Pox
- Food Allergies
- Mumps
- Spina Bifida
- Asthma
- Depression
- Headaches
- Rash
- Other (please describe): _____
- Atopic Dermatitis (Eczema)
- Diabetes
- Hepatitis
- Scoliosis
- Bedwetting
- Ear Infections
- HIV
- Seizure Disorder

Adult Illness:

I... Deny Any Adult Illness (es)

- Alzheimer's
- Chicken Pox
- Depression
- Eye Problems
- Hypertension
- Lupus Erythema
- Psychiatric Problems
- Suicide Attempt(s)
- Past history of similar symptoms to your current condition
- Anemia
- Crohn's/Colitis
- Diabetes (Insulin)
- Fibromyalgia
- Influenzal Pneumonia
- Multiple Sclerosis
- Scoliosis
- Thyroid Problems
- Arthritis
- CRPS (RSD)
- Diabetes (Non insulin)
- Heart Disease
- Liver Disease
- Parkinson's disease
- Seizure Disorder
- Vertigo
- Asthma
- CVA (stroke)
- Ear Infections (frequent)
- Hepatitis
- Lung Disease
- Pleurisy
- Shingles
- Cancer
- Cystic Kidney Disease
- Emphysema
- HIV
- Lupus Erythema
- Pneumonia
- STD's (unspecified)
- Other Illness (please be specific): _____

Surgeries:

I... Deny Any Surgery (ies)

- Angioplasty
- Coronary Artery Bypass
- Hemorrhoidectomy
- Laminectomy
- Tonsilectomy
- Appendectomy
- Cosmetic
- Hernia Repair
- Mastectomy
- Other (please be specific): _____
- Caesarian Section
- D & C
- Hysterectomy
- Pacemaker Insertion
- Cardiac Catheterization
- Dental Surgery
- Joint Reconstruction
- Rotator Cuff
- Carpal Tunnel Repair
- Gallbladder
- Joint Replacement
- Spinal Fusion

Ob/Gyn:

I... Deny Any Ob/Gyn Issue (s)

- have never been pregnant have been pregnant in the past am currently pregnant am uncertain if pregnant am not pregnant
- _____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
- _____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
- _____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History:

Age of Onset _____

My menses is Regular Irregular I am currently in Metaphase Menopause Date of Last Menses ____/____/____

Injuries:

I... Deny Any Injury (ies)

- Back Injury Broken Bones Severe Fall Fracture Disability
- Head Injury Industrial Accident Joint Injury Severe Laceration Motor Vehicle Accident
- Mild/Moderate Soft Tissue Injury Severe Soft Tissue Injury

Immunizations:

I... Deny Any Immunization (s)

- DTaP(diphtheria, tetanus, and pertussis) Flu Hepatitis A Hepatitis B Hepatitis C
- Influenza IPV (Polio) MMR (measles, mumps, and rubella) Pneumococcal
- PPD (Mantoux Test-TB) Small Pox TB Varivax (chicken pox) Whooping Cough (Pertussis)

Non-Drug Allergies:

I... Deny Any Non-Drug Allergy (ies)

- Animals Dairy Eggs Food Coloring Mold Pollen Wheat
- Other (please be specific): _____

EMPLOYMENT

Occupation: _____ Work (hrs/day): _____

Job Classification: Sedentary (<5lbs) Light (6-20lbs) Moderate (21-49lbs) Heavy (>50 lbs)

Lifting Frequency: Constant (66-100%/day) Frequent (33-65%/day) Occasional (0-32%/day)

Lifting Postures: Torso Knee Arm Shoulder High Near Off Posture

Work Activity Postures: (hrs/day)

Sitting: _____ Standing: _____ Walking: _____ Climbing: _____ Pushing: _____ Pulling: _____
Kneeling: _____ Reaching: _____ Twisting: _____

Repetitive Activities: (hrs/day)

Computer: _____ Phone: _____ Machinery: _____ Hand Tools: _____ Assembly: _____ Grasping: _____

Conditions Effect On Job Performance:

- Mild Painful (can do) Mod Painful (limits ability) Mod/Sev (limited duty) Sev (no limited duty) Sev (can't do limited duty)

SOCIAL HISTORY - Please indicate beside each activity whether you engage in it: Often= "O", Sometimes= "S", Never= "N"

- | | |
|----------------------------|-----------------------------|
| _____ Vigorous Exercise | _____ Family Pressures |
| _____ Moderate Exercise | _____ Financial Pressures |
| _____ Alcohol Use | _____ Other Mental Stresses |
| _____ Drug Use | _____ Other (specify) _____ |
| _____ Tobacco Use | _____ |
| _____ Caffeine | _____ |
| _____ High Stress Activity | _____ |

FAMILY HISTORY - Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age []	MOTHER Age []	SPOUSE Age []	BROTHER(S) Age []	SISTERS Age []	CHILDREN Age []
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

DAILY ACTIVITIES - Effects of Current Condition on Performance

- Care –Infirm Family: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Carrying Groceries: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Change Posn–Sit–Stand: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Climb Stairs: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Daily Pet Care: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Driving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Ext Computer Use: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Household Chores: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lift Children: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Bathing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Dressing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Shaving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sexual Activities: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sleep: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

Static Standing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
Walking: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
Yard Work: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
_____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform

INFORMED CONSENT

PATIENT NAME _____

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- ◆ **The nature of the chiropractic adjustment.**
I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.
- ◆ **The material risks inherent in chiropractic adjustment.**
As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
- ◆ **The probability of those risks occurring.**
Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke and other complications are generally described as "rare."
- ◆ **Ancillary treatment.**
In addition to chiropractic adjustments, I may use the following treatments:
Electrical Muscle Stimulation Long Axis Traction Hot Packs
Physical Therapy Intersegmental Traction Massage Therapy
Rehabilitation Exercises Therapeutic Light Spinal Decompression
- ◆ **The availability and nature of other treatment options.**
Other treatment options for your condition include:
 - ◆ Self-administered, over-the-counter analgesics and rest
 - ◆ Medical Care Supervised by your primary care physician
- ◆ **The risks and dangers attendant to remaining untreated.**
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. There is a possibility that non-treatment will complicate later rehabilitation.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Ann Marie Dahl, D.C. and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the treatment recommended. I also understand that the care given by Dr. Ann Marie Dahl, D.C. and Dahl Family Chiropractic, like any medical procedure, may not be effective. As such I understand that there is no guarantee of results. Having been informed of the risks, I hereby give my consent to that treatment.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)

AUTHORIZATION & RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

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