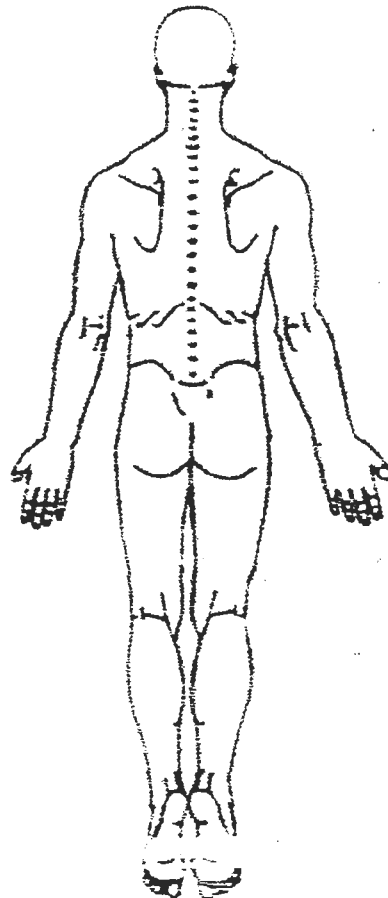
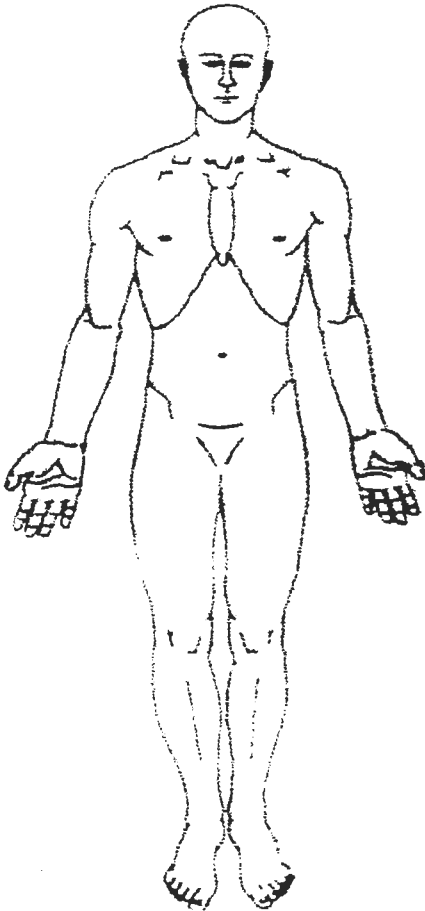


Confidential Patient Record

Name _____ **Sex** _____ **Age** _____ **DOB** _____ **Date** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Home _____ **Business** _____ **Fax** _____ **Mobile** _____
Social Security _____ **Driver's License** _____ **Email** _____
Occupation _____ **Employer** _____
Names/Ages of Children _____ **Marital Status (circle one)** MARRIED SINGLE WIDOWED DIVORCED
Name of Spouse _____ **Spouse's Employer** _____
Name and Phone of Emergency Contact _____ **Relationship** _____
How did you hear about our office? _____
Have you ever been to a chiropractor before? Y N **If yes, which doctor?** _____

Health Evaluation

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the right by circling the number that best represents your pain, where 1 is no pain and 10 is pain as bad as you can imagine.



Rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain on AVERAGE for the past WEEK.

1 2 3 4 5 6 7 8 9 10

Complaints ● Please rank your health complaints and rate their severity (on a scale from 1-10, 10 being the worst). This could include your current pain, a chronic injury (ex. "bad" knee or shoulder), weight concerns, etc.

Goals ● What are your goals for seeing Dr. Barry? _____

Limitations ● What limitations do you have, if any, in working with Dr. Barry (ex. Unwilling to take nutritional supplements, working in excess of 60 hours a week, won't give up smoking or alcohol, etc)?

Stress level ● Rate your stress level currently on a scale from 1-10 (10 being the most stress). Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, excessive fear, worry, anxiety, insomnia, road rage, not happy with life, depression, etc.
Overall stress: _____ Main reasons for stress _____

If over a level 5, what steps are you currently taking to reduce your stress? _____

Energy level ● List on a scale from 1-10 (1 is lowest, 10 is highest) what is your energy level during the following times:

AM _____ Afternoon _____ Evening _____ Late PM _____ After meals _____ Overall _____

Sleep Quality ● How is your sleep? (check all that apply)

Restful Restless Hard to get sleep Wake up often Nightmares

What time do you usually go to sleep? _____ Hours of sleep/night? _____

Exercise ● Do you exercise? _____ How often? _____ For how long per session? _____

Daily Habits ● For each of these items, specify if you consume them and how often (i.e. 2 cups/day).

Coffee/Tea: _____ Soda: _____ Alcohol: _____ Water: _____ Fast Food: _____

Vitamins/Minerals: _____

Allergies ● Please list any known allergies, including food allergies, environmental, seasonal, drug, etc.

Scars ● Describe any scars on your body (major and minor ones)

Medical History ● Please describe any conditions which are under the care of a physician.

Diagnosis _____

Date of onset _____ Duration of current symptoms _____

Doctor(s) involved, their specialty _____

How diagnosed (what tests)? _____

Current treatment (medication, etc.) _____

Treatment received in past, if any, and how it worked _____

Medications | Please list any medications you are taking, or have taken in the past, and for how long. State the reason for taking it.

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Muscle Relaxors | <input type="checkbox"/> Steroids (prednisone, anabolics, cortisone) |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Hormones (estrogen, progesterone, DHEA, testosterone, thyroid) | <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Yeast/Fungal Medications |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Blood Pressure Medication | | <input type="checkbox"/> Parasite Medication | |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Cardiac/Heart Medication | | | |

Surgeries/Hospitalizations | What surgeries, operations, traumas, fractures, car accidents, etc. have you had?

- | | | | | |
|---------------------------------------|--|-------------------------------------|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Breast Implants | <input type="checkbox"/> C-Sections | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Laparoscopy |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Biopsies | <input type="checkbox"/> D&Cs | <input type="checkbox"/> Implants/Prostheses | <input type="checkbox"/> Tonsils/Adenoids |

Other (please list all with brief details such as date, outcome, etc.) _____

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal		Paternal							
	Grandma	Grandpa	Grandma	Grandpa	Mother	Father	Brother	Sister	Onset	Outcome
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arthritis (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Review of Systems | Please check the "NOW" box for all conditions that you are now experiencing and mark the "PAST" box for any condition or symptoms experienced at any time in your life.

	↓ NOW	↓ PAST		↓ NOW	↓ PAST		↓ NOW	↓ PAST		↓ NOW	↓ PAST		↓ NOW	↓ PAST
General			Nose			G-I System			Neurologic			Conditions		
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Head			Lungs			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting/Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blacking out	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Bone			Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			Coughing phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscle ache	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Vascular			Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Flashes in vision	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	G-U System			Bone pain	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Spots in vision	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Mouth			Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>	Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet/hands	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Skin			Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Calf pain	<input type="checkbox"/>	<input type="checkbox"/>	Foul odor of urine	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	TIA's	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Decreased urination	<input type="checkbox"/>	<input type="checkbox"/>	Changes in moles	<input type="checkbox"/>	<input type="checkbox"/>	Headache unlike	<input type="checkbox"/>	<input type="checkbox"/>
Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	any previously	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>				Genital infection	<input type="checkbox"/>	<input type="checkbox"/>	Peeling	<input type="checkbox"/>	<input type="checkbox"/>	experienced		