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 _____

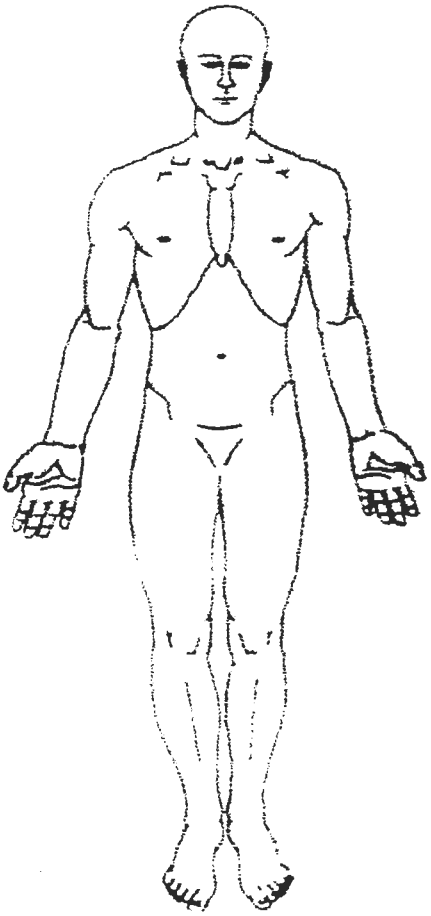
Name and Phone of Emergency Contact _____ Relationship _____

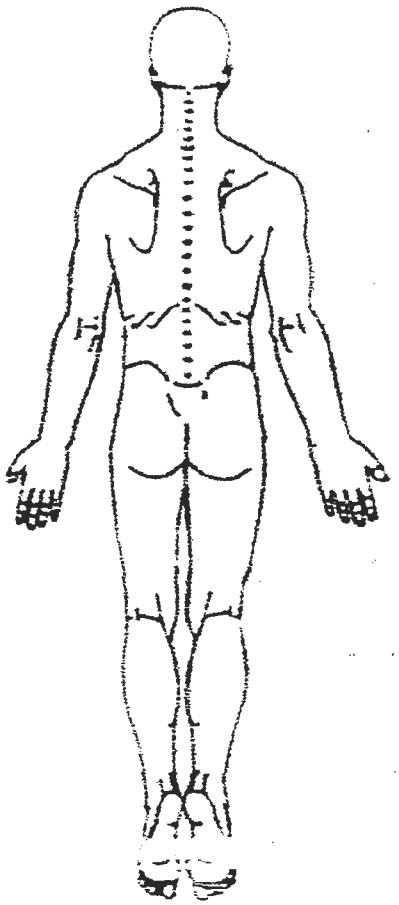
How did you hear about our office? _____

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. Olsen?_____

Limitations ● What limitations do you have, if any, in working with Dr. Olsen (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)
0 Restful 0 Restless 0 Hard to get sleep 0 Wake up often 0 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.

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

_____

_____

_____

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

- ❑ Appendectomy
- ❑ Arthroscopy
- ❑ Breast Implants
- ❑ Biopsies
- ❑ C-Sections
- ❑ D&Cs
- ❑ Eye Surgery
- ❑ Implants/Prostheses
- ❑ Laparoscopy
- ❑ 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	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Arthritis (type)	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Cancer (type)	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Mental Disease	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____
Thyroid Imbalance	❑	❑	❑	❑	❑	❑	❑	❑	_____	_____

Other _____

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
General		
Weight loss	❑	❑
Weight gain	❑	❑
Head		
Headache	❑	❑
Dizziness	❑	❑
Head trauma	❑	❑
Fainting	❑	❑
Blacking out	❑	❑
Eyes		
Change in vision	❑	❑
Cataracts	❑	❑
Light sensitivity	❑	❑
Flashes in vision	❑	❑
Spots in vision	❑	❑
Mouth		
Bleeding gums	❑	❑
Cold sores	❑	❑
Dentures	❑	❑
Sore throat	❑	❑
Jaw pain	❑	❑
Changes in taste	❑	❑
Hoarseness	❑	❑

	NOW	PAST
Nose		
Nosebleeds	❑	❑
Sinus problems	❑	❑
Lungs		
Difficulty breathing	❑	❑
Asthma	❑	❑
Pneumonia	❑	❑
Wheezing	❑	❑
Persistent cough	❑	❑
Coughing phlegm	❑	❑
Coughing blood	❑	❑
Tuberculosis	❑	❑
Vascular		
Chest pain	❑	❑
Palpitations	❑	❑
Ankle swelling	❑	❑
Cold feet/hands	❑	❑
Leg cramps	❑	❑
Calf pain	❑	❑
Varicose veins	❑	❑
Low blood pressure	❑	❑
High blood pressure	❑	❑

	NOW	PAST
G-I System		
Gas	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Ulcers	❑	❑
Vomiting/Nausea	❑	❑
Abdominal Pain	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Blood in stool	❑	❑
Hemorrhoids	❑	❑
Gall bladder disease	❑	❑
Liver disease	❑	❑
G-U System		
Difficulty urinating	❑	❑
Pain urinating	❑	❑
Blood in urine	❑	❑
Incontinence	❑	❑
Foul odor of urine	❑	❑
Increased urination	❑	❑
Decreased urination	❑	❑
Urinary infection	❑	❑
Genital infection	❑	❑

	NOW	PAST
Neurologic		
Seizures/Epilepsy	❑	❑
Strokes	❑	❑
Tingling sensation	❑	❑
Numbness	❑	❑
Weakness	❑	❑
Difficulty walking	❑	❑
Poor coordination	❑	❑
Muscle/Bone		
Joint pain	❑	❑
Stiffness	❑	❑
Muscle ache	❑	❑
Arthritis	❑	❑
Bone pain	❑	❑
Fractures	❑	❑
Dislocations	❑	❑
Skin		
Rash	❑	❑
Bruising	❑	❑
Brittle nails	❑	❑
Changes in moles	❑	❑
Itching	❑	❑
Peeling	❑	❑

	NOW	PAST
Conditions		
Hypertension	❑	❑
Diabetes	❑	❑
Thyroid condition	❑	❑
Heart condition	❑	❑
Rheumatic arthritis	❑	❑
Rheumatic fever	❑	❑
Glaucoma	❑	❑
Alcoholism	❑	❑
Cancer/Tumor	❑	❑
Polio	❑	❑
Parkinson's	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Anemia	❑	❑
Osteoporosis	❑	❑
Osteoarthritis	❑	❑
High cholesterol	❑	❑
Migraines	❑	❑
TIAs	❑	❑
Headache unlike any previously experienced	❑	❑