

Patient Health Record

Welcome to Hauck Chiropractic!

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific and individualized chiropractic care.

ABOUT THE PATIENT

Name _____

Address _____

City _____ State _____ Zip _____

Age _____ Birthdate ____/____/____ Gender M F

Home Phone _____ Work # _____

SS# _____ - _____ - _____

Employer _____

Type of work _____

Marital Status Mar. Sing. Div. Wid.

Family M.D. or clinic _____

How many children do you have? _____

Names _____ Age _____

E-mail address _____

Would you like us to email you our free weekly health tip? ? Yes ? No

ABOUT THE SPOUSE OR PARENTS

Name(s) _____

Employer _____

Type of Work _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to
Job Auto Fall Sports Daily Life
Chronic Discomfort Home Injury Other
Please explain _____

When did this health challenge begin? _____

Does this interfere with Work Sleep
Daily Routine Other Activities
Explain _____

What are **your** objectives in consulting us?

What are your health **goals** once these objectives have been met? _____

What other wellness professionals are currently a part of your health care team?
massage therapist acupuncturist
naturopath homeopath Other _____

Have you seen other professionals for this?
Yes No

Dr.'s Name (s) _____

Type of Treatment _____

Results _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits? _____

Previous Chiropractor's Name _____

Approximate Date of Last Visit _____

Has any *adult* in your family seen a Chiropractor? Yes No

Has any *child* in your family seen a Chiropractor? Yes No

Were you aware that

- ...Doctors of Chiropractic work with the nervous system? Yes No
- ...the nervous system controls all bodily functions and systems? Yes No
- ...Chiropractic is the largest natural healing profession in the world? Yes No
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

GOALS FOR MY CARE

Which best describes your reason for consulting our office?

I have a specific concern and require help only with this concern.

I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

I want to be healthier 5 years from now than I am today.

Please tell us the name of the last doctor who put you on a health development program:

_____ Were you able to stay with the program? Yes No

If so, how long? ___ months ___ years. What were your results? _____

_____ Were the results permanent? Yes No

MEDICATIONS I NOW TAKE

Stomach Medications	Stimulants
Pain Killers (including aspirin)	Blood Thinners
Muscle Relaxers	Anxiety/depression
Blood Pressure	Hormone Therapy
Insulin	Cholesterol

HEALTH HABITS

	Yes	No	
Do you smoke?			___ packs/day
Do you drink alcohol?			___ drinks/month
Do you drink coffee/soda?			___/day
Do you exercise regularly?	No	Moderate	Daily
Do you wear	Heel Lifts	Arch Supports	

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Severe or frequent headaches	Low energy	Shingles	For Women:	
Sinus problems	Heart surgery/ pacemaker	Kidney problems		Are you pregnant? Yes No
Dizziness	Heart murmur	Hepatitis		Are you nursing? Yes No
Loss of sleep	High/low blood pressure	Cancer	Are you taking birth control? Yes No	
Pain between the shoulders	Difficulty breathing	Chemotherapy	Do you experience painful periods? Yes No	
Frequent neck pain	Asthma	Anemia	Do you have irregular cycles? Yes No	
Numbness or pain in arms/legs/hands	Arthritis	Anxiety/Depression		
Lower back problems	Alcohol/drug abuse	Thyroid problems		
Digestive problems	Lowered immune system	Heart attack		
Ulcers/colitis	Diabetes	Carpal Tunnel		
	Irregular Bowel	Other		

Are you healthier now than you were 5 years ago? Yes No If yes, what did you do to accomplish this?

If no, why do you think your health has deteriorated over the last 5 years? _____

Will you be healthier 5 years from now than you are today? Yes No

Why or why not? _____

What would you like your health to be 5 years from now? _____

How many Medical Doctor's office visits did you and your family have last year?

None Less than 5 More than 5 More than 10 More than 20 Too many

THE POWER OF THE BODY

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical or emotional may cause these **subluxations**. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxations**.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following.

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR BIRTH:

	No	Yes	Explain:
1) Drugs/medicine/tobacco/alcohol in pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) Labor chemically induced?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) Forceps/Vacuum Extraction/C-section?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) Premature delivery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) Vaccinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) Falls in first year of life?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) Any health related problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR CHILDHOOD:

	No	Yes	Explain:
1) Any falls or injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) Allergy/Asthma or Respiratory problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) Ear Infections?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) Digestive Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) Hyperactivity?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) Any other health related problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT:

	No	Yes	Explain:
1) Auto Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) Work Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3) Sports Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4) Work Stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5) Family/Home Stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6) Prescription Drug Use?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7) Ever Hospitalized/Surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8) Recurring Illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9) Limited Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10) Poor Nutrition?	<input type="checkbox"/>	<input type="checkbox"/>	_____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor(s) to work with my condition through the use of adjustments, as he or she deems appropriate. I clearly understand and agree that all services rendered 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, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Patient or Guardian Signature: _____ Date: _____