PENNEY FAMILY CHIROPRACTIC

Welcome to Penney Family Chiropractic!

Patient Health Record

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask. 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 chiropractic care.

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About The Patient

Name_____ Birth date _____ Age _____

Address _____ City, State, Zip_____

Home Phone _____ Cell _____ Email Address _____

Number of Children _____ Name and Age of Children _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Type of work _____

Work Address _____

About The Spouse(if applicable)

Name _____ Employer _____

Work Phone _____ Type of work _____

In An Emergency, Contact

Name _____ Relationship _____

Work Phone _____ Home Phone _____

Cell Phone _____

Reason For The Visit

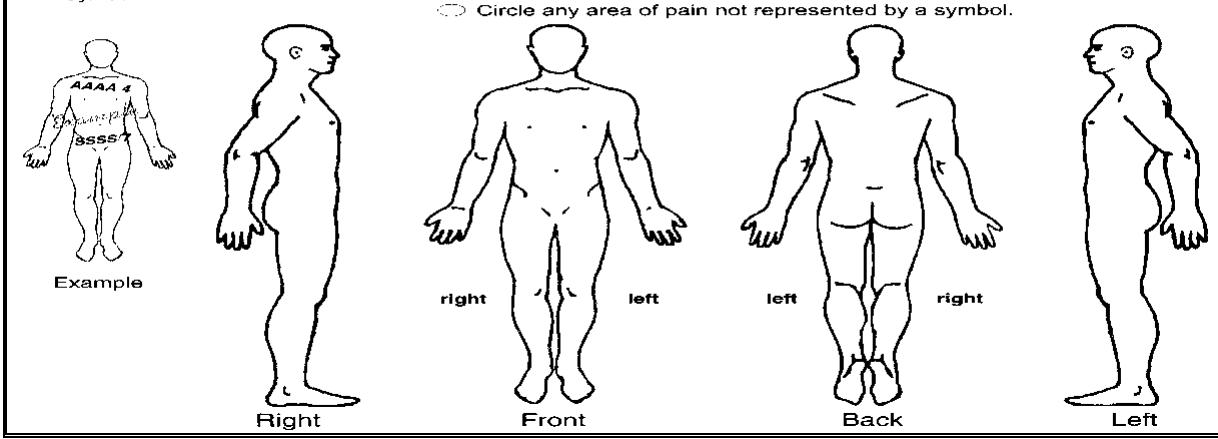
Is the purpose of this appointment related to ☐ Work ☐ Auto Accident

If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol.



What is your Primary Complaint?	
When did it begin?	
Has the condition: **(circle one)**	**Gotten Worse / Gotten Better / Stays the Same**
Describe where it is?	
Where does it travel?	
What is the intensity? **(circle one)**	**0 1 2 3 4 5 6 7 8 9 10(severe)**
How often do you have it? **(circle one)**	**Constant / days / week / mo**
How long does an episode last? **(circle one)**	**Constant / minutes / days**
What makes it better Or worse?	**Better:** **Worse:**
What have you done to try to help your complaint:	

What is your Second Complaint?	
When did it begin?	
Has the condition: **(circle one)**	**Gotten Worse / Gotten Better / Stays the Same**
Describe where it is?	
Where does it travel?	
What is the intensity? **(circle one)**	**0 1 2 3 4 5 6 7 8 9 10 (severe)**
How often do you have it? **(circle one)**	**Constant / days / week / mo**
How long does an episode last?	**Constant / minutes / days**
What makes it better Or worse?	**Better:** **Worse:**
What have you done to try to help your complaint:	

Has this condition occurred before? ☐ Yes ☐ No

Explain: _____

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Sitting ☐ Standing
☐ Lifting ☐ Walking ☐ Daily Routine

Explain: _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name (s): _____

Type of Treatment: _____

Results: _____

Experience With Chiropractic

How did you hear about our office? _____

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits? _____

Doctor's Name: _____

Approximate date of last visit: _____

Has any *adult* in your family seen a Chiropractor? _____

Has any *child* in your family seen a Chiropractor? _____

Awareness of Chiropractic Principles

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 professional in the world? ☐ Yes ☐ No
- ….if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No
- ….research shows that many of the health challenges that occur later in life have their origins during birth and the developmental years? ☐ Yes ☐ No

…….

Commitment to Health

On a scale of 0-10, how committed are you to correction of your main complaint or health concern? (circle one)

0 1 2 3 4 5 6 7 8 9 10

Health Conditions

Please **circle** all conditions you are experiencing, even if they seem unrelated to the purpose of this visit. Please put an **(x)** by all the conditions you have previously experienced.

NMS

- ☐ Headaches
- ☐ Neck Stiffness
- ☐ Pins/Needles in arms
- ☐ TMJ/Jaw Pain
- ☐ Pain between the Shoulders
- ☐ Neck Pain
- ☐ Numbness/Pain in Arms/Hand
- ☐ Low Back Pain
- ☐ Numbness/pain in Legs/Feet
- ☐ Pins/Needles in Legs/Feet
- ☐ Arthritis
- ☐ Disc herniation
- ☐ Scoliosis
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis

Visceral

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Excessive Thirst
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High/Low Blood Pressure
- ☐ Acid Reflux/Heartburn
- ☐ Lung Problems
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Weight Loss
- ☐ Loss of appetite
- ☐ Upset Stomach
- ☐ Ulcers
- ☐ Diabetes
- ☐ Anemia
- ☐ Difficult urination
- ☐ Painful urination
- ☐ Excessive urination
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Irritable Bowel
- ☐ Hemorrhoids
- ☐ Prostate Problems
- ☐ Infertility
- ☐ Fever
- ☐ Liver Disease
- ☐ Kidney Problems

Other

- ☐ Cancer
- ☐ Loss of Sleep
- ☐ Oversleeping
- ☐ Low Energy
- ☐ Confusion
- ☐ Mood Swings
- ☐ Depression
- ☐ Irritability
- ☐ Nervousness
- ☐ Anxiety

Special Senses

- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Dizziness
- ☐ Epilepsy

Female

- ☐ Pregnancy
- ☐ Nursing
- ☐ Difficult getting pregnant
- ☐ Miscarriage
- ☐ Menstrual Pain
- ☐ Menstrual Irregularities
- ☐ Hot Flashes
- ☐ Other _____
- _____
- _____

Medications I Now Take

- ☐ Nerve Pills
- ☐ Blood Thinners
- ☐ Blood Pressure Medicine
- ☐ Insulin
- ☐ Stimulants
- ☐ Muscle Relaxers
- ☐ _____
- ☐ Pain Killers(including Aspirin)
- ☐ Tranquilizers
- ☐ _____

Health Habits

	No	Yes	
Do you smoke?	☐	☐	_____packs/day
Do you drink alcohol?	☐	☐	_____drinks/day
Do you drink coffee or soda?	☐	☐	_____drinks/day

Do you exercise regularly?	☐ No	☐ Moderate	☐ Daily
Do you use:	☐ Heel lifts	☐ Inner Soles	☐ Arch Supports

For Women

	No	Yes
To the best of your knowledge, are you pregnant at this time?	☐	☐
Are you currently nursing?	☐	☐
Are you using birth control?	☐	☐
Method_____		
Do you experience painful menstrual cycles?	☐	☐
Do you have irregular menstrual cycles?	☐	☐

X-ray Release

This is to certify that Dr. Hollie or Dr. Scott and whomever they may designate as their assistant has my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.

Patient Signature: _____

Ownership of X-ray Films

I understand and agree that all the payments to the Doctors X-rays are for examination only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Authorization For Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as she/he deems appropriate.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services.

_____

Patient Signature Date

_____

Guardian or Spouse Signature Authorizing Care Date