



CONFIDENTIAL PATIENT HEALTH RECORD

Alternative Health & Chiropractic Wellness, 7 Brendan Way, Suite C, Greenville, South Carolina 29615 - (864) 331-9484

Dear Patient: This information is considered confidential. We need this information because your answers will help us to determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as comprehensive and accurate as possible while completing this form. Also, if you have questions about this form or don't understand a question, please don't hesitate to ask for assistance. Thank you.

Date: _____

Name _____ Home Phone: (____) _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Sex: Male Female Age: _____ Birth Date: ____/____/____ Social Security Number: _____

Marital Status: Single Married Widowed Divorced Have children? No Yes How Many? _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: (____) _____

Name of Spouse: _____ Occupation: _____

Employer: _____ Office Phone: (____) _____

IN CASE OF AN EMERGENCY, CONTACT: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext. _____

Referred by: _____

REASON FOR VISIT: _____

When did it begin? _____ (Date) Unknown

What caused it? _____ Unknown

Is this condition getting: Worse Better Staying the Same Unsure

Is the pain or discomfort: Constant Comes & Goes Localized Radiating Sharp Throbbing Dull Ache

Is this the result of any type of accident? Auto Work Home Other: _____ Date: _____

Are you disabled from work? Yes No Percentage _____% How Long: _____ (Date)

What treatment(s) have you already received for this condition? Medications Surgery Physical Therapy

Chiropractic Herbal Homeopathic Nutritional Massage Therapy Other: _____ None

Results: _____

1) Services provided by (Name): _____

Address: _____ Phone: (____) _____

Diagnosis: _____

Treatment: _____

2) Services provided by (Name): _____

Address: _____ Phone: (____) _____

Diagnosis: _____

Treatment: _____

How do these factors seem to affect your condition (Please check each as appropriate)?

	No Effect	Better	Worse		No Effect	Better	Worse
Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching up/down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During the night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	First thing in the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Time of greatest activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	While resting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Before meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	After meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-4 hours after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near end of day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Daily Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had this condition/problem before? Yes No If so, when? _____ (Date)

What care did you previously receive? _____ Was it effective? Yes No

PAST MEDICAL/HEALTH HISTORY

Please list any current and/or previous problems you have had with your health:

Condition	Age or Date	Treatment	Is the condition stabilized or resolved?
			Y N
			Y N
			Y N
			Y N
			Y N

Have you had any motor vehicle accidents? Yes No

Type: _____ When: _____ Treatment: _____
 Type: _____ When: _____ Treatment: _____

Have you had any fractures? Yes No

What: _____ When: _____ Treatment: _____
 What: _____ When: _____ Treatment: _____

Have you had any surgery (ies)? Yes No

Type: _____ When: _____ Doctor: _____ Results: _____
 Type: _____ When: _____ Doctor: _____ Results: _____

Do you have any surgical implants? No Yes Explain: _____

Have you had any major dental work for TMJ, Bridges, Dentures, Braces, etc.? No Yes

Explain: _____

Please list any medications (prescription or OTC), vitamins, herbs, supplements or the like that you are currently taking:

Item: _____ Amount each day: _____ For: _____
 Item: _____ Amount each day: _____ For: _____
 Item: _____ Amount each day: _____ For: _____
 Item: _____ Amount each day: _____ For: _____

Please list any allergies that you have, including medications, supplements, foods, cosmetics, and the like: None

Item: _____ Reaction: _____
 Item: _____ Reaction: _____
 Item: _____ Reaction: _____
 Item: _____ Reaction: _____

Date of last Physical Exam: _____ By Doctor: _____

Results: _____

Date of Last: Spinal X-ray _____ Spinal Exam _____ Blood Test _____ Urine Test _____
 Chest X-ray _____ Dental X-rays _____ Dental Exam _____ Vision Exam _____
 MRI, CT-Scan, Bone Scan _____

Family Health History	Age	Living	Heart Disease	Cancer	Stroke	Kidney Disease	Diabetes	Musculoskeletal (Back, Neck, Etc)	Other
Father		Y N							
Mother		Y N							
Brother/Sister		Y N							
Brother/Sister		Y N							
Brother/Sister		Y N							

Are there any other members of your paternal or maternal family with any significant history of disease (i.e. Cancer, Cardiovascular Disease, Osteoporosis, Stroke, Diabetes, Asthma, etc.) for which we should be aware? No Yes

What? _____

HEALTHY LIFESTYLE HABITS

Height: _____ inches

Weight: _____ pounds

Current Health Habits:

Do you...	No	Yes		No	Yes
Exercise at least 3 days/wk for 30 min.	<input type="checkbox"/>	<input type="checkbox"/>	Eat 5-9 Servings of Fruits/Vegs. a day	<input type="checkbox"/>	<input type="checkbox"/>
Drink 64 oz. of Water a day	<input type="checkbox"/>	<input type="checkbox"/>	Average 8 Hours Sleep (Per Night)	<input type="checkbox"/>	<input type="checkbox"/>
Have Regular Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Soundly Throughout the Night	<input type="checkbox"/>	<input type="checkbox"/>
Watch Television (_____ Hrs/Day)	<input type="checkbox"/>	<input type="checkbox"/>	Awaken Refreshed and Well Rested	<input type="checkbox"/>	<input type="checkbox"/>
Sex - Entirely Satisfactory	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Products (_____/Day)	<input type="checkbox"/>	<input type="checkbox"/>
Like Your Work (_____ Hrs/Day)	<input type="checkbox"/>	<input type="checkbox"/>	Take a Vacation (_____ Weeks/Year)	<input type="checkbox"/>	<input type="checkbox"/>

Rate your current level of stress from 1 to 10 (10 being the highest, 1 being the lowest): _____

In order to better assess your current state of health and wellness, please place a check mark in the column for the hour(s) where each event usually occurs on a given day.

DAY 1	MORNING (A.M.)												AFTERNOON/EVENING (P.M.)											
	LV		LG		LI		ST		SP		HT		SI		UB		KY		HC		TH		GB	
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Pain/Discomfort																								
Most Energy																								
Least Energy																								
Eat																								
Work																								
Exercise																								
Relax																								
Sleep																								

Do you have sufficient energy for your normal activities? Yes No Explain: _____

When was the last time you really felt good? _____

ATHLETICS/SPORTS PARTICIPATION

Do you participate in any leisure athletic activities/sports? No Yes If yes, please describe the particulars below.

EXPECTATIONS

What do you expect to achieve as a result of your visit today?

Have you ever visited a: Chiropractor Naturopath Homeopath Nutritionist Herbalist Massage Therapist

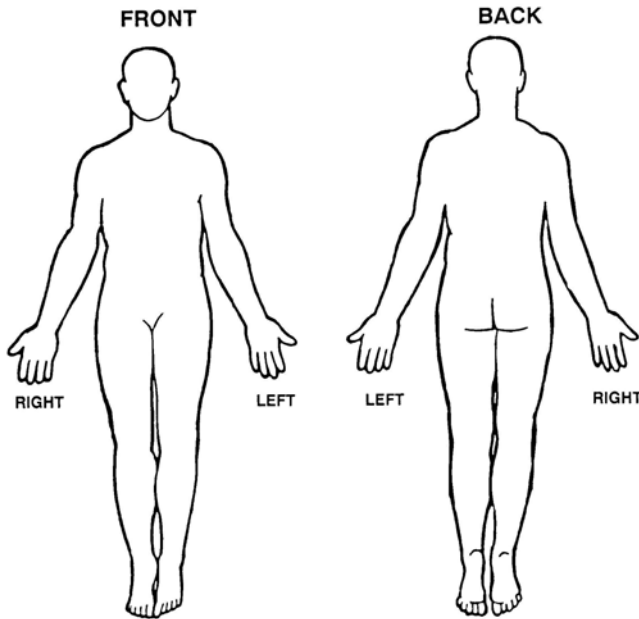
Reason: _____ Were you satisfied with the results? Yes No

Why? _____

Please don't write in this section. This space is reserved for doctor comments.

PAIN DRAWING ASSESSMENT

Draw the location of your pain on the body outlines below using the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face. Mark the severity of your pain or discomfort at the bottom of the page.



ACHE ZZZZ ZZZ	BURNING BBBB BBB	NUMBNESS XXXX XXX
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PINS & NEEDLES ==== ===	STABBING //// ///
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Percentage of pain in the neck: _____ %

Percentage of pain in the back: _____ %

Percentage of pain in the legs: _____ %

VISUAL ANALOG SCALE

What is your pain/discomfort level RIGHT NOW?

NO PAIN 1 2 3 5 6 7 8 9 10 WORSE POSSIBLE PAIN

What is your TYPICAL or AVERAGE pain/discomfort level?

NO PAIN 1 2 3 5 6 7 8 9 10 WORSE POSSIBLE PAIN

What is your pain/discomfort level AT ITS BEST (How close to "0" does your pain get at its best)?

NO PAIN 1 2 3 5 6 7 8 9 10 WORSE POSSIBLE PAIN

What percentage of your awake hours is your pain/discomfort at its best? _____ %

What is your pain/discomfort level AT ITS WORST (How close to "10" does your pain get at its worst)?

NO PAIN 1 2 3 5 6 7 8 9 10 WORSE POSSIBLE PAIN

What percentage of your awake hours is your pain/discomfort at its worst? _____ %

This is to certify that the information I provided, as documented in this Confidential Patient Health Record, is true and accurate to the best of my knowledge. In addition, I authorize Dr. Kramer to utilize this information as necessary to conduct a chiropractic and/or holistic health examination, determine an appropriate holistic diagnosis, and establish a plan of treatment.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

Please don't write below this line. This space is reserved for doctor comments.
