

CORY WILLIAM GOLD, D.C.

DIRECTOR, CHIROPRACTIC SERVICES

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____

Birth Date: _____ Age: _____

Address: _____

Sex: Male / Female

City _____ State: _____ Zip: _____

Home Phone: _____

Social Security #: _____

Cell Phone: _____

Driver's License #: _____

E-mail Address: _____

Business Employer: _____

Fax #: _____

Occupation: _____

Business Phone: _____

Name of Spouse: _____

Spouse's Employer: _____

Type of Work: _____

Names & Ages of Children: _____

Referred To This Office By: _____

Relationship: _____

Name & Number of Emergency Contact: _____

Who is Responsible for your bill, you and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Personal Health Insurance Carrier: _____

Health Card ID #: _____

Insured Person's Name: _____

Group #: _____

Insured Person's Date of Birth: _____

Primary Care Physician: _____

Insured Person's Social Security #: _____

Pharmacy: _____

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

Use the letters below to indicate the type and location of you sensations right now:
A=Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

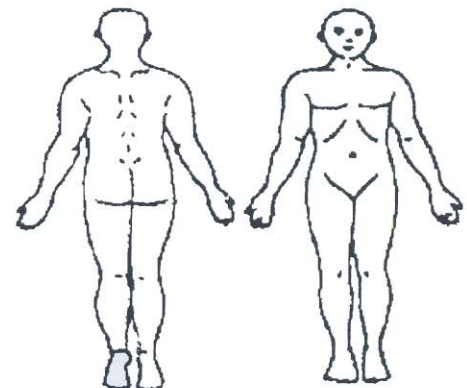
Is condition: Auto Related Work Related Other No Injury

Explain: _____

Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____



Please answer the following questions to the best of your knowledge.

1. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your life time? _____ NEVER

2. When was your last spinal Examination including X-rays? _____ NEVER

3. Have you ever been told that you have pinched nerve, spinal curvature, spinal arthritis, or inherited spinal problem? NO YES Please Explain _____

4. Subluxation or spinal misalignment cause decay and degenerative which result in grinding or cracking. Do you ever hear noises when you move your head, neck, low back or hips? NO YES

5. Spinal misalignments or subluxations can make you feel like you need to twist, stretch or crack your neck and back. Do you ever feel the need to “crack and pop” your neck or lower spine? NO YES

6. Poor posture leads to poor health, and often indicates a spinal problem and pinched nerve. How would you rate your posture?

POOR 1 2 3 4 5 6 7 8 9 10 Excellent

7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

Low 1 2 3 4 5 6 7 8 9 10 High

8. Chiropractic care is for optimal health and healing. However, most of our patients first seek our help when in a health crisis. What health concerns or crisis brought you to our office?

1. _____ 2. _____ 3. _____

9. Prescription medications may hide the severity of health problems, and hinder the body’s ability to heal. What Medications are you currently taking? _____

10. Slips & falls, motor vehicle accidents & sports injuries can cause serious spinal problems (even if not reported). Have experienced any trauma? NO YES _____

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

- Childhood Illness:** ADD Allergies/Hayfever Asthma Atopic Dermatitis Cerebral Palsy Chicken Pox
 None Depression Diabetes Fetal Drug Exposure Food Allergies Headaches Hepatitis
 Measles Mumps Rash Seizure Disorder Sickle Cell Anemia Spina Bifida
 Unusual Childhood Illnesses _____

- Adult Illnesses:** Anemia Arthritis Asthma Cancer Chicken Pox CRPS (RSD)
 None CVA (Stroke) Depression Diabetes (Insulin Dep) Diabetes (NIDDM - Noninsulin) Eye Problems Heart Disease
 Hepatitis Hypertension Kidney Disease Liver Disease Lung Disease Psychiatric Problems
 Seizures Similar Symptoms STD's Suicide Attempts Thyroid Problems

- Surgeries:** Angioplasty Appendectomy Caesarean Section Cardiac Catheterization Carpal Tunnel Repair Coronary Bypass
 None Cosmetic D&C Hemorrhoidectomy Hernia Repair Hysterectomy Joint Reconstruction
 Joint Replacement Laminectomy Mastectomy Pacemaker Insertion Spinal Fusion Tonsillectomy
 Gallbladder
 Other _____

Ob/Gyn: Describe: _____
 None

Injuries: Describe: _____
 None

- Immunizations:** Flu Hepatitis A Hepatitis B Hepatitis C MMR Pneumonia
 None PPD Small Pox TD Varivax

Non-Drug Allergies: Describe: _____
 None

FAMILY HISTORY

	Alive	Deceased	Condition
General Family	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

- Alcohol:** None Beer Liquor Social Consumption Wine Amount _____
- Diet:** High Fat Diet High Fiber High Protein High Salt Intake
 Low Calorie Intake Low Carbohydrate Low Fiber Low Salt Low Sugar

Education: Level or Degree Attained: _____

Substance: Denies Any Denies IV Drugs Not Used Since _____ Used Drugs For _____

Tobacco: Type _____ Amount _____

Other doctors seen for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

Drugs you now take: Nerve Pills Pain Killers Muscle Relaxers Blood Pressure Medicine Insulin Allergy Medicine
 Anti-Depressants Other: _____

Do you wear heel lifts? Yes No Side Lift Yes No Inter Soles Yes No Arch Supports Yes No
Orthotics Yes No

Any other conditions you feel we should know about - even if unrelated? _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if “NONE”.

Constitutional:	<input type="checkbox"/> Chills	<input type="checkbox"/> Daytime Somnolence	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Weight Gain	
	<input type="checkbox"/> None	<input type="checkbox"/> Weight Loss					
Eyes/Vision:	<input type="checkbox"/> Blindness	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain	
	<input type="checkbox"/> None	<input type="checkbox"/> Field Cuts	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Itching	<input type="checkbox"/> Photophobia	<input type="checkbox"/> Tearing
ENT:	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Dentures	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Discharge	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ear Drainage	
	<input type="checkbox"/> None	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Fainting	<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> History of Head Injury
	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> PND (Post Nasal Drip)	<input type="checkbox"/> Rhinorrhea (Runny Nose)	
	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Snoring	<input type="checkbox"/> Tinnitus (Ringing in Ears)	<input type="checkbox"/> TMJ			
Respiration:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Shortness of Breath (SOB)	<input type="checkbox"/> Sputum Production	<input type="checkbox"/> Wheezing	
	<input type="checkbox"/> None						
Cardio:	<input type="checkbox"/> Angina	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Claudication	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Orthopnea	
	<input type="checkbox"/> None	<input type="checkbox"/> Palpitations	<input type="checkbox"/> PND	<input type="checkbox"/> SOB with Exertion	<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Varicose Veins
Gastro:	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Belching	<input type="checkbox"/> Black Tarry Stools	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty Swallowing	
	<input type="checkbox"/> None	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Nausea	<input type="checkbox"/> Rectal Bleeding
	<input type="checkbox"/> Regurgitation	<input type="checkbox"/> Stool Caliber	<input type="checkbox"/> Stool Color	<input type="checkbox"/> Stool Consistency	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vomiting Blood	
Female:	<input type="checkbox"/> Breast Lumps/Pain	<input type="checkbox"/> Burning Urination	<input type="checkbox"/> Cramps	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Irregular Menstruation	<input type="checkbox"/> Urine Retention	
	<input type="checkbox"/> None	<input type="checkbox"/> Vaginal Bleeding	<input type="checkbox"/> Vaginal Discharge				
Male:	<input type="checkbox"/> Burning Urination	<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Hesitancy/Dribbling	<input type="checkbox"/> Prostate	<input type="checkbox"/> Urine Retention	
	<input type="checkbox"/> None						
Endocrine:	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Excessive Appetite	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Frequent Urination	
	<input type="checkbox"/> None	<input type="checkbox"/> Goiter	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Unusual Hair Growth	<input type="checkbox"/> Voice Changes	
Skin:	<input type="checkbox"/> Changes in Nail Texture	<input type="checkbox"/> Changes in Skin Color	<input type="checkbox"/> Hair Growth	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> History of Skin Disorders	<input type="checkbox"/> Hives	
	<input type="checkbox"/> None	<input type="checkbox"/> Itching	<input type="checkbox"/> Paresthesias	<input type="checkbox"/> Pruritis	<input type="checkbox"/> Rash	<input type="checkbox"/> Skin Lesions/Ucers	<input type="checkbox"/> Varicosities
Nervous:	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Facial Weakness	<input type="checkbox"/> Headache	<input type="checkbox"/> Limb Weakness	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Loss of Memory	
	<input type="checkbox"/> None	<input type="checkbox"/> Numbness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Slurred Speech	<input type="checkbox"/> Stress	<input type="checkbox"/> Strokes
	<input type="checkbox"/> Tremor	<input type="checkbox"/> Unsteadiness of Gait					
Psychologic:	<input type="checkbox"/> Anhedonia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Appetite	<input type="checkbox"/> Behavioral Change	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Confusion	
	<input type="checkbox"/> None	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Mood Change		
Allergy:	<input type="checkbox"/> Anaphalaxis	<input type="checkbox"/> Food Intolerance	<input type="checkbox"/> Itching	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Sneezing		
	<input type="checkbox"/> None						
Hematology:	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Blood Clotting	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Bruising	<input type="checkbox"/> Fatigue	
	<input type="checkbox"/> None	<input type="checkbox"/> Lymph Node Swelling					

Condition's Effect On Job Performance:

Mild Painful (can do) **Mod** Painful (limits ability) **Mod/Sev** (limited duty) **Sev** (no limited duty) **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

- Care –Infirm Family: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Carrying Groceries: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Change Posn–Sit–Stand: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Climb Stairs: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Daily Pet Care: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Driving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Ext Computer Use: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Household Chores: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lift Children: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Bathing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Dressing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Shaving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sexual Activities: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sleep: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Standing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Walking: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Yard Work: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform
- _____ **No Effect** **Mild** Painful (Can do) **Mod** Painful (limited) **Sev** Unable to Perform

Patient Signature _____ **Today's Date** ___/___/___