CONFIDENTIAL PATIENT HEALTH RECORD

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 By:**_____ _____
Emergency Contact: _____ **Relationship:** _____
Who is Responsible for your bill: □**You** *and/or* □ **Spouse** □ **Auto Insurance** □ **Medicare** □ **Insurance**
Health Insurance Carrier:_____ **Health Card ID#:**_____
Insured Person's Name: _____ **Group #:**_____
Insured's Date of Birth: _____ **Have You Had Previous Chiropractic Care?** _____
Insured's Social Security #:_____ **Name of Previous Chiropractor:** _____
Amount of Time Under Care of a Chiropractor?
***Exam For?** Self Family _____

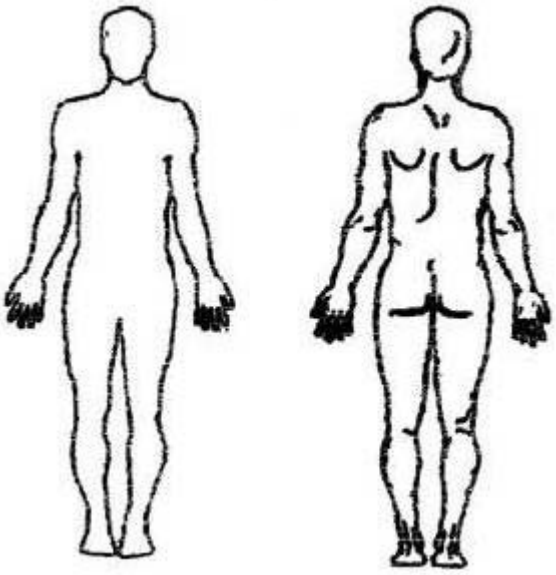
OFFICE PORTION:
Patient ID#:_____ **Visit Date/Time:** _____

Case Type: **Cash** **Insurance** **Medicare** **Personal Injury**

CURRENT HEALTH CONDITION

***Chief Complaint (why you're here today)**
_____
_____
_____

PLEASE OUTLINE ON DIAGRAM THE AREA OF DISCOMFORT*



When did this condition begin?_____
Has is occurred before? □ **Yes** □ **No**
Is condition: □ **Auto Related** □ **Work Related** □ **Other** □ **No Injury**
Explain: _____
_____
Date of Accident:_____
Time of Accident:_____
Complaint/Pain Onset Date:_____

What are your health goals?_____

Patient Name:_____ **Date:**_____

CHIEF COMPLAINT – HPI FORM

MECHANISM OF ONSET:

1.) *Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (example: fall, auto injury, sports trauma, repetitive motion of the job.)*

_____

_____

SYMPTOMS: *When this problem is at it's worst, can you explain in your words how exactly it feels? Does it radiate?*

_____

QUALITY:

□ Burning □ Diffuse □ Dull/Aching □ Localized □ Sharp
□ Shooting □ Stabbing □ Tingling □ Radiating □ Other_____

TIMING:

□ Worse AM □ Worse during afternoon □ Worse w/ Activity □ Intermittent □ Constant □ Worse PM
*How often do you find yourself suffering from this problem?*_____
*How long does the problem last? (Get all the details of timing)*_____

DAILY ACTIVITIES: **Effects of Current Condition on Performance**

Care – Family Member				
Carrying Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Change Positions –				
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Climbing Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Lifting Children	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Reading/Concentration	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Self Care – Bathing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Self Care – Shaving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Sleep	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Yard Work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform

MEDICATIONS: What medications are you currently taking, and for what conditions?

_____

_____

_____

Patient Name:_____ **Date:**_____

RECREATIONAL ACTIVITY:

_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform
_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to perform

YOUR LIFE REVIEW – LIFESTYLE CHIROPRACTIC EXPERIENCE
Please Check All That Apply (even if not seemingly related to your concern to note how nerve interference is impacting you HEALTH

□ Headaches	□ Menstrual Irregularity	□ Fainting	□ Numbness in Fingers/Toes
□ Buzzing/Ringing in Ears	□ Nervousness/Depression	□ Problems Urinating	□ Loss of Smell/Taste
□ Cold Feet/Hands	□ Mood Swings/Irritability	□ Back Pain	□ Neck Pain
□ Sleeping Problems	□ Diarrhea	□ Tension	□ Upset Stomach/Heartburn
□ Fevers	□ Hot Flashes	□ Loss of Balance/Dizziness	
□ Scoliosis	□ Fatigue	□ Pins & Needles in Legs/Arms	□ Ulcers
□ Light Bothers Eyes	□ Constipation		

Do these conditions disrupt:	Social Life	Family	Ability to Exercise
(Circle all that apply)	Sleep Patterns	Career	Other

What methods have you tested to relieve your pain? (Circle all that apply.)

Exercise	Physical Therapy	Massage	Diet Changes
Drugs	Supplements	Surgery	Other_____

Were any of these methods successful at addressing the problem? Y / N
If "No", circle the following if applicable:

The problem worsened	I want to be energetic again
I want answers and results	I want to be healthy

On a scale of 1 to 10, ten being the highest, rate the importance of finding the cause of your problem:
1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of the problem?
1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, ten being the highest, rate the importance of quality of life?
1 2 3 4 5 6 7 8 9 10

What results do you want? (Circle all that apply.)
Reduced Pain Restored Health Maintained Health

What excuses have stopped you from being well?
Time Money Other_____

FAMILY HISTORY

(Please check all that apply.)

□ High Blood Pressure	□ Tuberculosis	□ Arthritis	□ Allergies	□ Asthma
□ Recurrent Infections	□ High Stress	□ Stroke	□ Cancer	□ Scoliosis
□ Nervous Disorder	□ Headaches	□ Vaccine Reaction	□ Mental Illness	□ Heart Disease
□ Diabetes	□ Other _____			

TERMS OF ACCEPTANCE/ CHIROPRACTIC INFORMED CONSENT AGREEMENT

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and, if necessary, diagnostic x-rays on me by Dr Jeff Gancas at Living Healthy Chiropractic and/or anyone authorized by the same doctor. I further understand and am informed that Living Healthy Chiropractic does not offer to diagnose or treat any disease or condition other then vertebral subluxation. However, if during the course of a chiropractic spinal examination, the doctor encounters non-chiropractic or unusual findings, he will inform me and offer a referral. Regardless of what the disease is called, the doctor will not offer to treat it, nor will he offer advice regarding treatment prescribed by others.

The main objective at Living Healthy Chiropractic is to eliminate interference to the expression of the body's innate wisdom. As in all health care, there are some slight risks to treatment. I do not expect the doctor to be able to anticipate or explain all risks and combinations. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluation.

I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

SIGNATURE: _____ **PRINT: _____**

WITNESS: _____ **DATE: _____**