

Confidential Patient Health Record

Name _____ Home Phone _____

Street _____ City _____ Zip _____

Age _____ Birth Date _____ Marital Status: S M W D How many children? _____

Social Security No. _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Other Nearest Relative _____ Phone _____

Who referred you to our office? _____

Previous Chiropractic care? Yes _____ No _____ Reason for consulting this office

By whom _____ Eliminating symptoms or disease _____

For what _____ Preventing symptoms of disease _____

When _____ Xrays taken? _____ Maximizing health potential _____

Is your condition due to an accident? Yes _____ No _____

If yes: Auto _____ Home _____ Leisure _____ Sports _____ Other _____

Chief complaints: (What is bothering you?)

1. _____

How long? _____

What makes it feel better? _____

What makes it feel worse? _____

What does it feel like? _____

Does the pain radiate? _____

How often does it bother you? _____

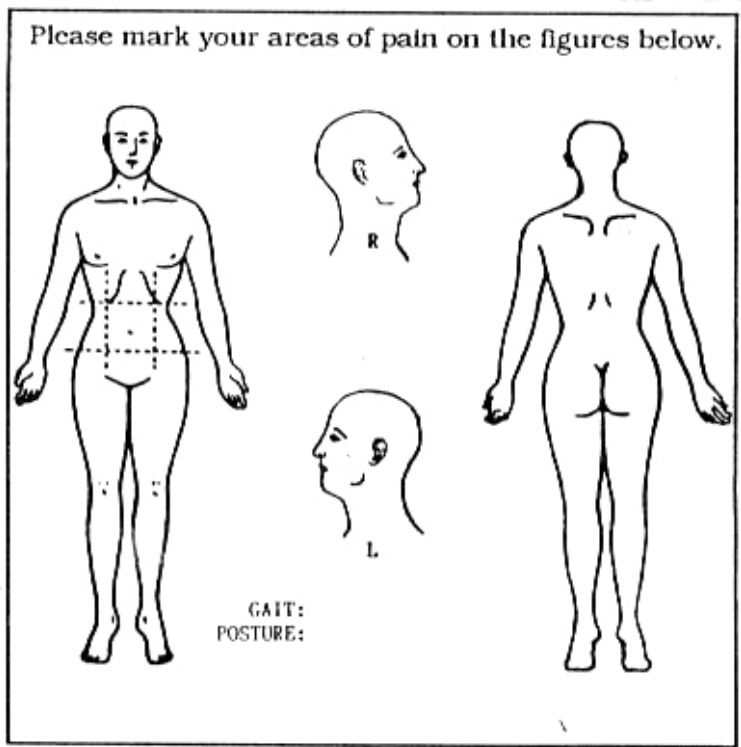
Describe any treatment previously received for this complaint _____

Chief complaints: (What is bothering you?)

2. _____
- How long? _____
- What makes it feel better? _____
- What makes it feel worse? _____
- What does it feel like? _____
- Does the pain radiate? _____
- How often does it bother you? _____
- Describe any treatment previously received for this complaint _____
- _____

Chief complaints: (What is bothering you?)

3. _____
- How long? _____
- What makes it feel better? _____
- What makes it feel worse? _____
- What does it feel like? _____
- Does the pain radiate? _____
- How often does it bother you? _____
- Describe any treatment previously received for this complaint _____
- _____



Circle current conditions...Check former conditions:

HEAD AND NECK AREA:

Headaches	Stiff neck	Neck pain	
Poor posture	Light sensitivity	Tension	Sinus disorder
Restricted neck movement	Zig Zag flashes	High blood pressure	Head colds
Nervousness	Nausea	Tremors	Sore throat
Personality change	Eye or sinus pain	Insomnia	Hoarseness
Hayfever/allergies	Facial spasms	Dizziness	HIV – positive (AIDS)
Skin disorder	Anxiety	Vertigo	
Visual disturbances	Irritability	Earache R L	

UPPER BACK AREA

Shoulder pain – front – back	Asthma	Numbness/tingling arms/hands R L	Chronic cough
Upper back pain	Sore aching muscles across shoulders	Pain around collar bone	Spitting up phlegm/blood
Arm pain R L	Chest Colds	Joint stiffness/pain – arms/hands R L	Difficult breathing
Swollen joints-arms/hand R L	Thyroid condition	Rapid beating heart	Elbow pain
Arthritis	Respiratory disorder	Slow beating heart	Wrist pain
Restricted movement - shoulder/arm R L	Hot/cold spots arms/hands R L		Hand pain

MID BACK AREA

Middle back pain	Abdominal pain	Liver disorder	Tiredness
Scoliosis	Gall Bladder problems	Fevers	Hiatal hernia
Chest pain	Jaundice	Low blood pressure	Heart attack
Pain beneath/below breast bone	Shingles	Stomach disorder	Kidney disorder
Restricted movement-mid-back	Gas/heartburn/gastritis	Food allergies	
Rib cage pain	Psoriasis		

LOW BACK AND PELVIS

Low back pain	Upper leg pain R L	Numbness/tingling-legs/feet R L	Prostatitis
Painful tailbone	Lower leg pain R L	Leg cramps R L	Colitis
Hip pain	Foot pain R L	Diarrhea	Diverticulitis -
Sciatica	Hernia	Constipation	Impotence
Knee pain R L	Buttock pain	Hemorrhoids	Cramping
Swollen joints-leg/foot R L	Varicose veins	Changes in urination	Irregular/painful period
Restricted movement-leg/foot R L	Cold feet	Poor circulation	
	Hot/cold spots-legs/feet R L		

Other health symptoms: _____

Describe any family health problems (parents, spouse, children): _____

List any surgeries you have had and the dates.

1. _____
2. _____
3. _____

List any medication you are taking. (Include over-the counter and vitamins)

1. _____
2. _____
3. _____

List any accidents in which you received injuries and dates (car, slips and falls, work, etc.)

1. _____
2. _____
3. _____

List serious illnesses you have had and dates diagnosed, (cancer, heart attack, stroke, infections, etc.)

1. _____
2. _____
3. _____

List leisure activities:

- | Sedentary | Strenuous |
|-----------|-----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |

Are you pregnant? Yes _____ No _____ Do you wear dentures? Yes _____ No _____

Date of last physical exam _____ By whom? _____

Does anyone else in your family suffer from this or a similar condition? Yes _____ No _____

Many of our patients plan to file for insurance benefits for the care they receive in our office. If you have insurance, please include the name and type of coverage below. If you would like, we will check with the company to determine your eligibility for benefits and what they are.

Insurance Company _____

Type of coverage:

_____ Workman's Comp. _____ Personal Liability (Negligent Party) _____ Comp. Med. Pay _____ Homeowner's _____ Group Health _____ Other

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Richard L. Hilton will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Richard L. Hilton will be credited to my account upon receipt. However, 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 care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS# _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

Information taken by _____

Pain Rating Scale

Name: _____

Date: _____

Instructions: Please choose the number which best describes your pain in each of the questions below:

1. What is your pain RIGHT NOW?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

2. What is your TYPICAL or AVERAGE pain?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain

3. What is your pain AT ITS WORST?

0	0	0	0	0	0	0	0	0	0	0
0	1	2	3	4	5	6	7	8	9	10

No Pain

Unbearable Pain