PATIENT RECORD & HEALTH HISTORY

PLEASE FILL OUT BOTH SIDES OF THIS FORM COMPLETELY

OFFICE USE ONLY
DATE ____________________
FILE # ____________________
ENTERED BY: ______________

Patient's Name ____

Street Address ____

City, State, Zip ____

Home Phone ______________________ Work Phone ______________________

Cell Phone ______________________ E-mail ______________________

Preferred Method of Contact : [ ] Home Phone [ ] Work Phone [ ] Cell Phone [ ] E-mail [ ] US Postal Mail

Employer ______________________ Occupation ______________________

Date of Birth ______________________ Social Security Number ______________________

Race: [ ] American Indian [ ] Asian [ ] Black [ ] Hawaiian or other Pacific Islander [ ] White [ ] Prefer not to answer

Ethnicity : [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Prefer not to answer

Preferred Language: [ ] English [ ] Spanish [ ] Other ________________

Marital Status (check one) [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Spouse's Name ________________ Occupation ______________ Ages of Children __________

Nearest Relative ________________ Phone ______________ Relationship __________

Insurance Information: [ ] No Insurance [ ] Medicare [ ] Medicaid [ ] Major Medical/Health Ins [ ] Workman's Compensation

[ ] Personal Injury (Motor Vehicle Collision or Slip and Fall) Insurance Company Name: ______________________

Member Name ________________ Member # ______________ Member Date of Birth __________

Were you referred by another person (friend or physician)? [ ] yes [ ] no If yes, who may we thank? ________________

If not, how did you find out about our office? [ ] Yellow Pages [ ] Sign [ ] Radio [ ] Website [ ] Insurance Book [ ] Other __________

Patient's Statement of Problem ____

What Happened? ______________________________ Was the pain gradual? [ ] yes [ ] no

Date of condition or injury __________ Have you ever had same or similar symptoms? [ ] yes [ ] no If yes, when? __________

Lost time from work? [ ] yes [ ] no If yes, how long? ________ Date returned to work __________

Have you seen another physician for this condition? [ ] yes [ ] no If yes, who? ________________ What did he/she do for the condition? ______________________ May we contact them to discuss treatment? [ ] yes [ ] no

Are you taking ANY prescribed medications ? [ ] yes [ ] no Are you taking any over the counter medications? [ ] yes [ ] no If yes to either question, what medication are you taking and why are you taking it ? ______________________

Are you allergic to any medications? [ ] yes [ ] no If yes, what? ______________________

Do you exercise? [ ]Daily [ ] 2-3 times/week [ ] Other ________ [ ]No If yes, doing what? ______________________

Are you a smoker/tobacco user? [ ] yes, how many packs per day? ________ [ ] Former Smoker/tobacco user [ ] Never Smoker/tobacco user

How many alcoholic beverages do you consume per week? ________ How many caffeinated beverages do you consume per day? ________

(Women) Are you pregnant? [ ] yes [ ] no Nursing? [ ] yes [ ] no Taking Birth Control Pills? [ ] yes [ ] no

I understand and agree to authorize PAUL S. TASSIN, DC and whomever he may designate as assistants to administer whatever examination and treatments as deemed necessary.

If under 18: I hereby authorize PAUL S. TASSIN, DC and whomever he may designate as assistants to administer whatever examination and treatment as deemed necessary to my ________________ (relationship to child).

Patient's Signature or Parent/Guardian's Signature ______________________ Date ______________

Provider Representative's Signature ______________________ Date ______________

CONFIDENTIAL PATIENT CASE HISTORY

PLEASE COMPLETE EACH QUESTION THOROUGHLY. WE NEED ALL OF THE FACTS ABOUT YOUR HEALTH BEFORE WE ACCEPT YOUR CASE. THIS IS A CONFIDENTIAL HEALTH REPORT. THANK YOU!

Have you ever had previous chiropractic care? [ ] yes [ ] no If yes, please list the date of the last visit, Doctor's name and the condition you were treated for. ____________________

Family History of Health Problems

Mother ____________________

Father ____________________

Brothers____________________

Sisters ____________________

Have you ever been knocked unconscious? [ ] yes [ ] no If yes, How and when? ____________________

Have you ever fractured or broken a bone? [ ] yes [ ] no If yes, which bone(s), how and when? ____________________

____

List Surgical Operations and Years.

1.) ____________________

2.) ____________________

3.) ____________________

4.) ____________________

List any motor vehicle collisions, work injuries, severe falls, gun shot wounds, etc. and the dates of each occurrence.

1.) ____________________

2.) ____________________

3.) ____________________

4.) ____________________

Do you have any Allergies? [ ] yes [ ] no If yes, what are you allergic to? ____________________

____

Mark "C" for the following conditions that you have currently. Mark "P" for conditions that you have had in the past.

[ ] C [ ] P Alcoholism	[ ] C [ ] P Heart Disease	[ ] C [ ] P Bladder Conditions	[ ] C [ ] P High Cholesterol	[ ] C [ ] P Depression
[ ] C [ ] P Drug Dependency	[ ] C [ ] P Thyroid Conditions	[ ] C [ ] P Polio	[ ] C [ ] P Dry Skin	[ ] C [ ] P Psychiatric Care
[ ] C [ ] P Hardening of the Arteries	[ ] C [ ] P Asthma	[ ] C [ ] P Stroke	[ ] C [ ] P Bruise Easily	[ ] C [ ] P Hernia
[ ] C [ ] P Arthritis	[ ] C [ ] P Allergies	[ ] C [ ] P Tuberculosis	[ ] C [ ] P Numbness/Tingling in Arms	[ ] C [ ] P Prostrate Problems
[ ] C [ ] P Osteoporosis	[ ] C [ ] P Bronchitis	[ ] C [ ] P Ulcers	[ ] C [ ] P Numbness/Tingling in Legs	[ ] C [ ] P Herpes
[ ] C [ ] P Rheumatoid Arthritis	[ ] C [ ] P Emphysema	[ ] C [ ] P Rheumatic Fever	[ ] C [ ] P Constipation	[ ] C [ ] P Gonorrhea
[ ] C [ ] P Epilepsy	[ ] C [ ] P Liver Disease	[ ] C [ ] P Headaches	[ ] C [ ] P Diarrhea	[ ] C [ ] P Venereal Disease
[ ] C [ ] P AIDS/HIV	[ ] C [ ] P Anemia	[ ] C [ ] P Anorexia	[ ] C [ ] P Goiter	[ ] C [ ] P Vaginal Infections
[ ] C [ ] P Cancer	[ ] C [ ] P Bleeding Disorders	[ ] C [ ] P Bulimia	[ ] C [ ] P Herniated Disc	[ ] C [ ] P Breast Lumps
[ ] C [ ] P Diabetes	[ ] C [ ] P Cataracts	[ ] C [ ] P Multiple Sclerosis	[ ] C [ ] P Mononucleosis	[ ] C [ ] P Miscarriage
[ ] C [ ] P Gout	[ ] C [ ] P Glaucoma	[ ] C [ ] P Kidney Disease	[ ] C [ ] P Hepatitis	[ ] C [ ] P Mumps
[ ] C [ ] P Appendicitis	[ ] C [ ] P Chicken Pox	[ ] C [ ] P Fractures	[ ] C [ ] P Measles	[ ] C [ ] P Whooping Chough
[ ] C [ ] P Tumors	[ ] C [ ] P Scarlet Fever	[ ] C [ ] P Pneumonia	[ ] C [ ] P Typhoid Fever	[ ] C [ ] P Parkinson's Disease
[ ] C [ ] P Growths	[ ] C [ ] P Tonsillitis	[ ] C [ ] P Pacemaker	[ ] C [ ]P High Blood Pressure	Other : ____________