Welcome To Our Office!

8930 Brecksville Rd
Brecksville, OH 44141

Confidential Health History

Date: _____

Name_____ Date of Birth _____ Age _____

Address_____City_____ State_____ Zip_____

SS#_____-_____-_____ Male / Female Email Address _____

Cell Phone # _____ Home Phone # _____

Occupation_____ Employer_____ Work # _____

Employer's Address_____

City_____ State_____ Zip Code_____

___ Married ___ Single Spouse's Name_____

Primary Insured's Name_____ Insured's DOB_____

How Many Children Do You Have? _____ Children's Ages _____

Emergency Contact Name_____ Phone # _____

Who Referred You To Our Office? _____

What Is The Reason For Your Visit?

Please list any recent accidents or falls: ___ Car Accident ___ Work Injury ___ Other _____

What is your primary complaint? _____

How long have you been experiencing this problem? _____

On a scale of 1-10, how severe is it at its worst? 1 2 3 4 5 6 7 8 9 10

I Have ___ Been Hospitalized ___ Been Seen By Another Doctor ___ Never Received Treatment For This Problem

Is there a secondary complaint? _____

How long have you been experiencing this problem? _____

On a scale of 1-10, how severe is it at its worst? 1 2 3 4 5 6 7 8 9 10

I Have ___ Been Hospitalized ___ Been Seen By Another Doctor ___ Never Received Treatment For This Problem

Have You Ever Received Chiropractic Care? ☐Yes ☐No Last Visit Date?_____

Please List Over The Counter Medications, Dosage and Frequency

_____

Please List Your Current Prescription Medications

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

Do You Drink Alcoholic Beverages? ☐Yes ☐No How many drinks per week? ___ 1 - 4 ___ 5 - 10 ___ +10

Do You Smoke? ☐Yes ☐No How Much? ___ 1pack/day or less ___ More than a pack/day

Do You Exercise? ☐Yes ☐No How Often? ___ Less than 1x/wk ___ 2-3x/wk ___ More than 3x/wk

Do You Have Any Allergies? (Specify)_____

Are You Pregnant? ☐Yes ☐No ☐Not Sure Date of Last Period / Due Date?_____

Past and Present Medical History

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Patient Name _____ Date _____

Please place a "C" next to Current symptoms. Mark "P" next to symptoms you have had in the Past.

Musculoskeletal:

___ Arthritis
___ Hip Disorder
___ Osteoporosis
___ Fracture
___ Plates/Pins/Screws
___ Red/Swollen Joints
___ Gout
___ Implants
___ TMJ issues

Neurological:

___ Difficulty concentrating
___ Seizures
___ Memory issues
___ Sleeping issues
___ Weak muscles
___ Dizziness
___ Loss of smell or taste
___ Numbness
___ Loss of vision or hearing
___ Epilepsy
___ Headache
___ Pins and Needles
___ Stroke

Head & ENT:

___ Blurred or double vision
___ Difficulty swallowing
___ Headaches or Migraines
___ Recent hearing loss
___ Swollen lymph nodes
___ Chronic ear infections
___ Ear or hearing problems
___ Hoarseness
___ Ringing in the ears
___ Cataracts
___ Glaucoma
___ Sinus trouble
___ Sore throat

Cardiovascular:

___ Blood clots
___ Heart defects
___ Difficulty breathing
___ High blood pressure
___ Palpitations
___ Chest pain or tightness
___ Coronary artery disease
___ Excessive bruising
___ High Cholesterol or Triglycerides
___ Swollen legs or feet
___ Heart attack
___ Heart murmur
___ Varicose veins
___ Low blood pressure
___ Rheumatic fever

Respiratory:

___ Apnea
___ Emphysema
___ Shortness of breath
___ Asthma
___ Persistent cough
___ Tuberculosis
___ Coughing blood
___ Pneumonia
___ Wheezing

Gastrointestinal:

___ Abdominal pain
___ Changes in bowel habits
___ Constipation
___ Gastric reflux
___ Irritable bowel syndrome
___ Nausea or vomiting
___ Black or bloody stool
___ Colon cancer or colon polyps
___ Crohn's disease
___ Ulcer
___ Jaundice
___ Pancreatitis
___ Bloating
___ Colitis
___ Food sensitivities
___ Hemorrhoids
___ Liver disease
___ Severe diarrhea

Genitourinary:

___ Blood in urine
___ Painful or frequent urination
___ Incontinence
___ Sexual dysfunction
___ Kidney stones
___ Urinary infections

Endocrine:

___ Cushing's syndrome
___ Heat or cold intolerance
___ Steroid treatments
___ Diabetes
___ Pancreatic conditions
___Testosterone deficiency
___ Excessive thirst
___ Increase urination
___ Thyroid problems

Dermatological:

___ Change in hair or nails
___ Excessive acne
___ Hyper/hypo pigmentation
___ Bruise easily
___ Excessive hair loss
___ Psoriasis
___ Eczema
___ Rashes
___ Skin cancer

Surgical and Family History

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Patient Name _____ Date _____

Past Surgical History

(Please list the year of surgery and use the additional lines as necessary)

_____ Knee arthroscopy (R/L)	_____ Shoulder arthroscopy (R/L)	_____ Thyroid
_____ Spine surgery (neck/back)	_____ Joint replacement	_____ Hernia repair
_____ Bypass (Heart or Limb)	_____ Cardiac catheterization	_____ Hysterectomy
_____ Ligament repair/replacement	_____ Pins/Plates/Screws	_____ Injections

Please list any other surgery you may have had in the past not listed above: _____
_____
_____
_____

Family History

(Please check all that apply to your family)

____ Bleeding disorder	____ Coronary artery disease	____Hepatitis
____ Cancer	____ Heart Disease/Attacks	____Seizures
____ Lung Disease	____ Rheumatoid arthritis	____Kidney disease

Please list any other disease that a member of your family may have that is not listed above: _____
_____
_____
_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy has been made available to me by Brecksville Physical Medicine. This describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

By signing this authorization you acknowledge and agree that Brecksville Physical Medicine may use or disclose medical records for the purpose(s) of receiving payment, insurance benefits, insurance denials, insurance audits, intent to reconcile account, intent to help patient and training purposes.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature _____ **Date** _____
Would you like a copy of the Privacy Notice (4 pages)? _____ Yes _____ No

Optional: In addition I would like to give my consent for release of health or financial information to the following individual (this does not include copies of medical records or reports):

Name _____Relationship _____Date of birth _____

Patient Signature _____ Date _____

CONSENT FOR CARE AND TREAMENT

I _____(print name) do hereby agree and give my consent for Brecksville Physical Medicine to perform diagnostic procedures, render medical care and treatment judged medically necessary by our physicians. I hereby authorize Brecksville Physical Medicine to obtain any medical information from other providers or facilities that they may need to acquire to make informed judgment for the course of my treatment or the decision for procedures.

Patient Signature _____ **Date** _____

Consent to treat a minor

Patient Name: _____

Guardian Name: _____

Guardian Signature: _____ Date _____