Confidential Patient Health Record DATE _____

PERSONAL HISTORY

Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

Contact information: Please check the box next to the number you prefer we use to contact you:

[ ] Home Phone _____ [ ] Cell Phone_____

[ ] Work Phone: _____

Email: _____ (*We will never sell or give your email address to anyone. By giving us your email you are giving us permission to contact you about office events—schedule changes, workshops etc.)*

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ]Divorced [ ] Separated

Work Status: [ ] Employed [ ] Unemployed [ ] Student [ ] Retired (from type of work?) _____

Employer: _____ Type of Work: _____

Name of Spouse _____ Spouse's Birth Date _____

Spouse's Employer _____ Type of Work _____

Name & Number of Emergency Contact _____ Relationship _____

Do you have health insurance? [ ] Yes [ ] No Policy Holder: [ ] Self [ ] Spouse [ ] Parent [ ] Other

If the Policy Holder is not yourself or your spouse, please fill out the information below:

Name of insured _____ Insured's Birth Date _____

Insured's address _____

Demographic Information:

Living Status: [ ] Live Alone [ ] Live with spouse [ ] Live with: _____

Race/Ethnicity: [ ] White [ ] Black / African American [ ] Hispanic / Latino [ ] American Indian [ ] Alaskan Native
[ ] Native Hawaiian [ ] Pacific islander [ ] Other: _____

Health History Information:

Smoking Status: [ ] Never Smoked [ ] Former Smoker [ ] Current Smoker - Every Day [ ] Current Smoker - Some Days

Alcohol Intake: [ ] No alcohol [ ] Casual drinker [ ] Moderate drinker [ ] Heavy drinker
[ ] Drink only beer [ ] Drink only wine

Caffeine Intake: [ ] none [ ] < 3 drinks/day [ ] 3-6 drinks/day [ ] >6 drinks/day

Drug Use: [ ] No drug use [ ] Recreational Drug use [ ] Addiction

Exercise Status: [ ] Never Exercise [ ] Daily Exercise [ ] Weekly Exercise [ ] Walk [ ] Run [ ] Swim

Allergies:

Medication: [ ] Penicillin [ ] Sulfa drugs [ ] Iodine [ ] Antibiotics [ ] Other:_____

Food: [ ] Dairy [ ] Gluten/Wheat [ ] Soy [ ] Seafood [ ] Peanuts [ ] Other: _____

Environmental: [ ] Pollen [ ] Dust [ ] Grass [ ] Trees [ ] Animals [ ] Hay Fever [ ] Mold [ ] Latex [ ] Chemicals

Other: _____

Surgeries: [ ] Appendix [ ] Tonsils [ ] Gall Bladder [ ] Hernia [ ] Knee Replacement [ ] Knee Surgery
[ ] Hip Replacement [ ] Back Surgery [ ] Hysterectomy [ ] Prostate Removed [ ] Cataract
[ ] Coronary (heart) Bypass [ ] Carotid Artery

Other Surgeries: _____

_____

Major Illnesses:

Please check off any diseases or conditions you have or have had in the past:

[ ] Asthma	[ ] Emphysema	[ ] COPD	[ ] Lung Cancer
[ ] Heart Disease	[ ] Congestive Heart Failure	[ ] High Blood Pressure	[ ] Liver Disease
[ ] Diabetes	[ ] Thyroid Problems	[ ] Celiac Disease	[ ] Colitis
[ ] Colon Cancer	[ ] Prostate Cancer	[ ] Rheumatoid Arthritis	[ ] Multiple Sclerosis
[ ] Parkinson's Disease	[ ] Alzheimer's / Dementia	[ ] Osteoporosis	[ ] Stroke
[ ] HIV / AIDS	[ ] Depression	[ ] Chronic Fatigue	[ ] Pre-Diabetes / Insulin Resistance

[ ] Other Serious Illness: _____

Medications: Please list all medications you are currently taking. If you have a list made out already, we will be happy to make a copy of it

Type	Medication Name	How Long?
[ ] Antacids / Stomach		
[ ] Antibiotics		
[ ] Antidepressants		
[ ] Anti-Diabetics / Blood Sugar		
[ ] Anti-Inflammatory		
[ ] Blood Pressure Meds		
[ ] Cholesterol Meds		
[ ] Hormone Replacement		
[ ] Contraceptives		
[ ] Other		

Family History: Please check off any conditions your family members have had

Mother: [ ] cancer [ ] diabetes [ ] heart disease [ ] high blood pressure [ ] kidney disease [ ] stroke
[ ] none of the above Deceased? [ ] Yes [ ] Cause of death? _____

Father: [ ] cancer [ ] diabetes [ ] heart disease [ ] high blood pressure [ ] kidney disease [ ] stroke
[ ] none of the above Deceased? [ ] Yes [ ] Cause of death? _____

Sister(s): [ ] cancer [ ] diabetes [ ] heart disease [ ] high blood pressure [ ] kidney disease [ ] stroke
[ ] none of the above Deceased? [ ] Yes [ ] Cause of death? _____

Brother(s): [ ] cancer [ ] diabetes [ ] heart disease [ ] high blood pressure [ ] kidney disease [ ] stroke
[ ] none of the above Deceased? [ ] Yes [ ] Cause of death? _____

List any health conditions that may run in your family: _____

_____

Please list any hospitalizations (for more than just testing) you have had: _____

_____

_____

HISTORY OF COMPLAINT:
Please identify the conditions that have brought into this office:

Primary: _____

Secondary:_____

Third:_____

Fourth:_____

On a scale of **1** to **10** with **10** being the most severe and zero being not at all, rate how much your problems bother you by ***circling the number:***

Primary complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Secondary complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint**:** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem (s) begin? _____

Have you suffered with this or a similar problem in the past? [ ] Yes [ ] No

If **Yes,** how many times? _____ When was the last episode? _____

Have you tried other forms of treatment for this problem? (over the counter or prescription medicine, doctor, orthopedist, neurologist, physical therapy, acupuncture, other) [ ] Yes [ ] No

If **Yes**, what types: _____

If **Yes,** list names of doctors: _____

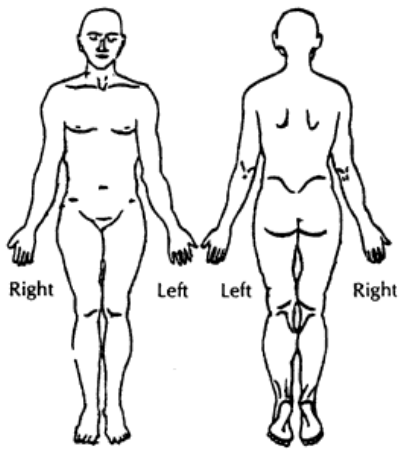
Does anyone in your family suffer from a similar condition? [ ] No [ ] Yes Who?_____

What makes your symptoms feel worse? _____

What makes them feel better? _____

Has your problem recently been:
[ ] getting worse [ ] getting better [ ] staying the same

When is the problem at its worst? [ ] AM [ ] PM [ ] mid-day
[ ] late PM [ ] no worse time [ ] other _____



Please mark the areas on the diagram with the **following letters** to describe your symptoms:
A=Aching **S**=Sharp/Stabbing **B**=Burning **D**=Dull **R**=Radiating **T**=Tingling **N**=Numb

I hereby authorize payment made directly to Dr. Brian Smith DC/Southern Ocean Chiropractic for all benefits which may be payable under a healthcare plan or from other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Dr. Brian Smith DC/Southern Ocean Chiropractic for any and all service I receive at this office.

_____ _____
Signature date completed