Rockwall Health Center
2880 Ridge Rd
Rockwall, TX 75032
(469) 769-1009

PATIENT HEALTH RECORD

NAME:		DATE:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:		CELL PHONE:
EMAIL:		
DOB:	AGE:	SEX:
OCCUPATION:		
EMPLOYER NAME:		ADDRESS:
WORK PHONE:		BEST TIME TO CONTACT:
STATUS: ☐ SINGLE	☐ MARRIED	☐ DIVORCED ☐ WIDOWED
SPOUSE'S NAME:		SPOUSE'S OCCUPATION:
NUMBER OF CHILDREN:		AGES:
REFERRED BY:		
HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ☐ YES		☐ NO
PERSON TO CONTACT IN CASE OF EMERGENCY?		
RELATIONSHIP TO PATIENT?		PHONE:

LIST ALL SURGERIES/SERIOUS ILLNESS/HOSPITALIZATIONS (INCLUDE YEARS IN BRACKETS)
WERE YOU TAUGHT PROPER BODY MOVEMENT & CARE? ☐ YES ☐ NO
DID/DO YOU SMOKE? ☐ YES ☐ NO
DID/DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

DIET (DO YOU EAT HEALTHY FOODS?) ☐ YES ☐ NO
DO YOU TAKE ANY WHOLE FOOD SUPPLEMENTS? ☐ YES ☐ NO
HAVE YOU BEEN IN ACIDENTS? ☐ YES ☐ NO
HAVE YOU HAD SURGERY & ORGANS REMOVED/REPLACED? ☐ YES ☐ NO
DRUGS? (PRESCRIPTIVE OR NON-PRESCRIPTIVE) ☐ YES ☐ NO
TEETH PROBLEMS? ☐ YES ☐ NO
EYE PROBLEMS? ☐ YES ☐ NO
HEARING PROBLEMS? ☐ YES ☐ NO
EXERCISE REGULARLY? ☐ YES ☐ NO
SLEEPING HABITS? NIGHTMARES? ☐ YES ☐ NO
DID/DO YOU HAVE OCCUPATIONAL STRESS? ☐ YES ☐ NO
PHYSICAL STRESS? ☐ YES ☐ NO
MENTAL STRESS? ☐ YES ☐ NO
HOBBIES/SPORTS INJURIES? ☐ YES ☐ NO
SLEEPING POSTURE: ☐ SIDE ☐ STOMACH ☐ BACK
OTHER TRAUMAS OR PROBLEMS:

MAJOR PRESENT COMPLAINT (BE BRIEF)	STARTED ON:
PAINS ARE: ☐ SHARP ☐ DULL ☐ CONSTANT ☐ INTERMITTENT	
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION/PAIN?	
WHAT ACTIVITIES LESSEN YOUR CONDITION/PAIN?	
IS CONDITION WORSE DURING CERTAIN TIME OF THE DAY?	
IS THIS CONDITION INTERFERING WITH: ☐ WORK ☐ SLEEP ☐ ROUTINE ☐ OTHER	
IS CONDITION GETTING PROGRESSIVELY WORSE? ☐ YES ☐ NO	

OTHER DOCTORS SEEN FOR THIS CONDITION:

ANY HOME REMEDIES?

OTHER SYMPTOMS?

☐ HEADACHES	☐ DIZZINESS	☐ DEPRESSION
☐ NECK PAIN	☐ FACE FLUSHED	☐ LIGHTS BOTHER EYES
☐ SLEEPING PROBLEMS	☐ NECK STIFF	☐ LOSS OF MEMORY
☐ BACK PAIN	☐ PINS &NEEDLES IN LEGS	☐ EARS RING
☐ NERVOUSNESS	☐ PINS & NEEDLES IN ARMS	☐ FEVER
☐ TENSION	☐ NUMBNESS IN FINGERS	☐ FAINTING
☐ IRRITABILITY	☐ NUMBNESS IN TOES	☐ LOSS OF SMELL
☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ LOSS OF TASTE
☐ FATIGUE	☐ DIARRHEA	☐ BUZZING IN EARS
☐ FEET COLD	☐ HANDS COLD	☐ STOMACH UPSET
☐ CONSTIPATION	☐ COLD SWEATS	☐ LOSS OF BALANCE

HAVE YOU BEEN UNDER DRUG & MEDICAL CARE?

☐ YES

☐ NO

WHAT MEDICATIONS ARE YOU TAKING?

IS THERE A FAMILY HISTORY OF:

OFFICE POLICIES

1. Our practice is a general chiropractic health care practice. We do not accept personal injury cases that have the potential of being litigated. Therefore, we...
   A. Do not accept Worker's Compensation cases.
   B. Do not accept accident cases (vehicle or otherwise) that were caused by another person, business, or vehicle, or have the potential of being litigated.
   C. Do not accept Medicaid or any other insurances.

2. X-rays are not made to determine when or where to adjust, as this is determined by neuro-muscular stress testing.
X-rays are needed to determine if any disease process, fracture, malformation, or spinal degeneration is present that would make spinal adjusting contraindicated.

3. Your acceptance as a patient is based on my findings relative to your symptoms and their relationship to your neuro-musculoskeletal manifestations. The acceptance of your case does not promise a cure; however, it does indicate by my evaluation you have definite neuro-musculoskeletal indicators that could have a relationship to your symptoms.

4. it is the policy of our office that you pay completely for services when they are rendered.

5. We endeavor to serve our patients to the best of our ability and professional training and we expect you, by becoming a patient to follow the doctor's recommended treatment program. This is necessary to gain optimum benefit in your case.

If you have any questions concerning any of the policies above, please contact the front desk BEFORE continuing with your forms.

By signing this policy sheet, you are stating you understand and will abide by the policies.

Signed: _____ Date: _____