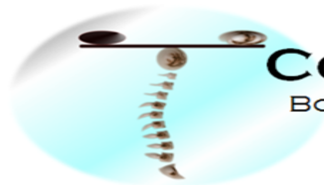
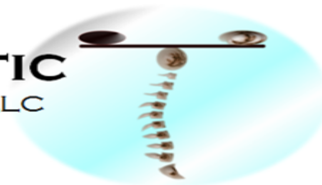


COMPLETE LIFE CHIROPRACTIC

BOLD LIFE CHIROPRACTIC, LLC ◇ WHITE CHIROPRACTIC, LLC
427 E MAIN STREET PRATTVILLE, AL 36067
(334) 356-5571



Confidential Patient Health Record

Today's Date: _______________

Personal Information

Name: ____ ______________
LAST FIRST MIDDLE PREFERRED NAME

Address: ____

City: ____________________ State: ______ Zip: ____________ Home Phone: ____________________

Birth Date: ________________ Age: _______ Sex: Male / Female Cell Phone: ____________________

Driver's License #: ____________________ State: ______ Email: ______________________

Would you like to receive text message appointment reminders? ☐ Yes ☐ No

Work Name: ______________________________ Occupation/Job Title: ____________________

Work Phone: ____________________ Name of Supervisor: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: ______________________________

Children (Name & Age): ____

Are you seeking care today as a result of an automobile accident or a work-related accident/injury? ☐ ***Yes*** ☐ ***No***

How did you hear about us? ____

Emergency Contact: ____________________ Phone: ____________________

Relationship: ☐ Spouse ☐ Parent ☐ Relative ☐ Friend ☐ Other ______________

Have you ever visited a chiropractor? ☐ Yes ☐ No Who? ________________ When? ________________

Current Health Condition

Why are you being seen today? ____

____

Date when condition STARTED? ________________ Has this ever occurred before? ☐ Yes ☐ No
When? ________________________

This condition is: ☐ Auto Related ☐ Job Related ☐ Home Injury ☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause

☐ Other Explain: ____

Have you seen any other doctor(s) for this condition? ☐ Yes ☐ No Who? ____________________

Type(s) of Treatment? ____

Were you satisfied with the results of your treatment? ☐ Yes ☐ No

Explain: ____

____

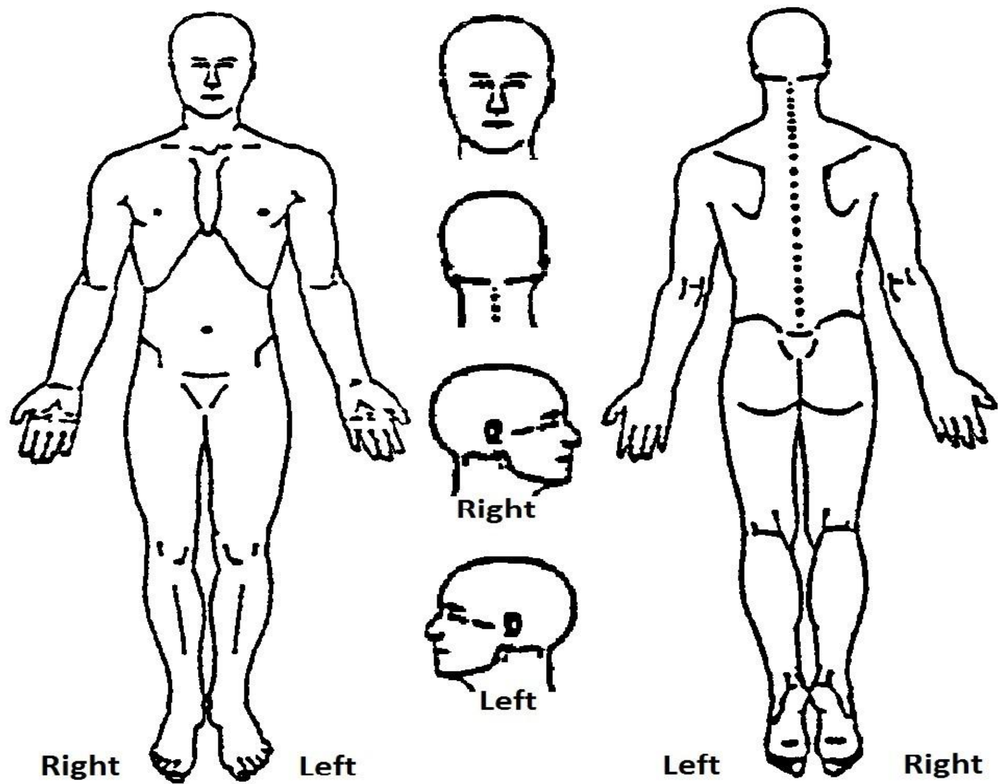
Do you suffer with any other condition(s) than the one(s) you are seeing us about today?

If so please list: ____

____

Use the letters below to show on figure to the right the type and area your of complaint(s).

Key:
- **A** = Ache
- **D** = Dull
- **B** = Burning
- **X** = Excruciating
- **S** = Stabbing
- **O** = Shooting
- **T** = Throbbing
- **W** = Weakness
- **N** = Numbness
- **P** = Pins & Needles / Tingling



Complaint	Mark ALL that apply below	Use a "**B**" or "**W**" in the space provided if the activity makes your complaint better or worse
1)	□ Achy □ Burning □ Throbbing □ Weakness □ Stabbing □ Dull □ Shooting □ Excruciating □ Numbness □ Pins & Needles/Tingling Does your pain radiate? □ No □ Yes, Where? ___ How severe is your complaint? **LOW** 1 2 3 4 5 6 7 8 9 10 **HIGH**	___ Standing ___ Any Movement ___ Sitting ___ Rest ___ Lying Down ___ Everyday Use ___ Walking
2)	□ Achy □ Burning □ Throbbing □ Weakness □ Stabbing □ Dull □ Shooting □ Excruciating □ Numbness □ Pins & Needles/Tingling Does your pain radiate? □ No □ Yes, Where? ___ How severe is your complaint? **LOW** 1 2 3 4 5 6 7 8 9 10 **HIGH**	___ Standing ___ Any Movement ___ Sitting ___ Rest ___ Lying Down ___ Everyday Use ___ Walking
3)	□ Achy □ Burning □ Throbbing □ Weakness □ Stabbing □ Dull □ Shooting □ Excruciating □ Numbness □ Pins & Needles/Tingling Does your pain radiate? □ No □ Yes, Where? ___ How severe is your complaint? **LOW** 1 2 3 4 5 6 7 8 9 10 **HIGH**	___ Standing ___ Any Movement ___ Sitting ___ Rest ___ Lying Down ___ Everyday Use ___ Walking
4)	□ Achy □ Burning □ Throbbing □ Weakness □ Stabbing □ Dull □ Shooting □ Excruciating □ Numbness □ Pins & Needles/Tingling Does your pain radiate? □ No □ Yes, Where? ___ How severe is your complaint? **LOW** 1 2 3 4 5 6 7 8 9 10 **HIGH**	___ Standing ___ Any Movement ___ Sitting ___ Rest ___ Lying Down ___ Everyday Use ___ Walking
5)	□ Achy □ Burning □ Throbbing □ Weakness □ Stabbing □ Dull □ Shooting □ Excruciating □ Numbness □ Pins & Needles/Tingling Does your pain radiate? □ No □ Yes, Where? ___ How severe is your complaint? **LOW** 1 2 3 4 5 6 7 8 9 10 **HIGH**	___ Standing ___ Any Movement ___ Sitting ___ Rest ___ Lying Down ___ Everyday Use ___ Walking

List any/all medications, vitamins, and supplements you are currently taking. Be specific.

Medication/Vitamin/Supplement	Dosage (amount)	Why do you take this?	How long have you taken this?

Do you wear any of the following? □ **Heel Lifts** □ **Innersoles** □ **Arch Supports** □ **Orthotics** □ **Other**___

REVIEW OF SYSTEMS- Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, because other issues may affect your overall course of care. If left blank it is assumed that you are denying currently or ever having any of the symptoms or problems listed below.

Constitutional

□ chills □ daytime drowsiness
□ fever □ fatigue
□ weight changes (gain or loss) □ night sweats
□ other: ____

Eyes/Vision

□ change in vision □ eye pain
□ glasses/contacts □ light sensitivity
□ glaucoma □ itchy eyes
□ cataracts □ other: _________________

Ears, Nose and Throat

□ ear drainage □ sinus infections
□ hearing loss or difficulty □ postnasal drip
□ ear ache/pain □ nosebleeds
□ ringing in ears □ headaches
□ sore thoat or hoarseness □ difficulty swallowing
□ snoring □ TMJ problems
□ loss of sense of smell □ other: _________________

Cardiovascular

□ chest pain □ heart murmur
□ heart problems □ claudication (leg pain/ache)
□ heart palpitations □ swelling of legs/ankles
□ high or low blood pressure □ varicose veins
□ difficulty breathing lying down □ ulcers
□ waking at night with shortness of breath
□ other: ____

Respiratory

□ asthma □ cough
□ wheezing □ coughing up blood
□ shortness of breath □ recent respiratory infection
□ sputum production □ other: _________________

Allergy

□ sneezing □ runny nose/watery eyes
□ itching □ rash
□ nasal congestion □ other: _________________

Skin

□ itching □ skin lesions/ulecers
□ rash □ varicose veins
□ hives □ changes in nail texture
□ changes in skin color □ history of skin disorder
□ other: ____

Endocrine

□ heat or cold intolerance □ voice changes
□ diabetes □ unusual hair growth or loss
□ goiter □ excessive thirst
□ abnormal appetite □ excessive urination
□ other: ____

Gastrointestinal

□ heartburn □ difficulty swallowing
□ nausea □ vomitting
□ excessive belching □ diarrhea
□ abdominal pain □ constipation
□ hemorrhiods □ jaundice
□ abnormal stool □ other: _________________

Nervous System

□ loss of memory □ facial weakness
□ dizziness □ limb weakness
□ unsteady gait □ stroke
□ seizures □ slurred speech
□ numbness □ tremors
□ sleep disturbances □ other: _________________

Female □ NA

□ pregnacy □ menstrual irregularity
□ birth control □ hormone therapy
□ menstrual cramping □ breast lumps/pain
□ difficult or irregular urination □ breast or cervical cancer
□ vaginal discharge □ other: _________________

Psychological

□ depression □ confusion
□ anxiety □ insomnia
□ bi-polar disorder □ convulsions
□ changes in behavior or mood
□ other: ____

Male □ NA

□ difficult or irregular urination □ prostate problems
□ erectile dystuncion □ other: _________________

Hematological

□ anemia □ easily bruised
□ blood clotting □ bleeding
□ lymph node swelling □ blood transfusion
□ other: ____

Family History Mark ALL that apply below

	Diabetes	Heart Problems	Cancer	Kidney Problems	Arthritis	Stroke	Mental Disorders	Autoimmune Disorders
Mother	□	□	□	□	□	□	□	□
Father	□	□	□	□	□	□	□	□
Sibling	□	□	□	□	□	□	□	□
Other Relative	□	□	□	□	□	□	□	□

Please list any current or past health conditions not already mentioned on these forms. CIRCLE your current conditions.

____

____

____

____

Surgery(ies) **Please write the approximate DATE of the procedure immediately after the procedure.**

____

____

____

____

Injury(ies) **Mark and list ALL injuries. Write the approximate DATE of the injury in the space provided.**

□ motor vehicle accident ______________________________

□ back injury ______________________________

□ head injury ______________________________

□ fall (severe) ______________________________

□ laceration ______________________________

□ fracture(s) ______________________________

□ loss of consciousness ______________________________

□ disability ______________________________

□ joint injury ______________________________

□ soft tissue injury (other than surgery) ______________________________

□ other: ____

Social History **Mark ALL that apply below**

Tobacco: □ I **do** use tobacco
□ I **do not** use tobacco
□ I live with a smoker
□ I quit smoking ______________________

I use tobacco _____________ times a □ day □ week □ month

Alcohol: □ I **do** use alcohol
□ I **do not** use alcohol
□ I quit drinking ______________________

I use alcohol _____________ times a □ day □ week □ month

Females ONLY **□ NA** **Mark ALL that apply below**

I AM: □ not pregnant □ currently pregnant □ unsure if I am pregnant

Past pregnancy(ies): □ C-section □ vaginal delivery □ miscarriage

With my signature below, I hereby authorize the doctor to perform chiropractic care as he deems appropriate, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid to the doctor for x-rays, if needed, is for the examination only and the x-ray negative(s) will remain the property of this office, where they will be on file and available for observation at any time while I am a patient of this office.

I clearly understand and agree that the doctors at Complete Life Chiropractic do not accept health insurance assignment. I also understand that all services rendered to me are charged directly to me, and I am personally responsible for payment in full at the time of service.

By signing below, I agree that I am responsible for any and all bills incurred during the course of my treatment.

Patient's Name: ____

Patient's Signature: ____ **Date:** ________________

Guardian Authorizing Care: ____

Guardian Signature: ____ **Date:** ________________