

# CONFIDENTIAL PATIENT HEALTH RECORD

## Personal Injury

Russ C. Redd, DC 1269 South Main Street  
(919) 556-2014 Wake Forest, NC 27587



Today's Date \_\_\_/\_\_\_/\_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  
 Close to home/work  Dr. \_\_\_\_\_  Yellow pages  Drove by  Hospital  Insurance Plan

### Personal Information

Title:  Mr.  Ms.  Mrs.  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ ext \_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

### Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ ext \_\_\_\_

### Employment Information

Business Name: \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ ext \_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Employer's Email Address: \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

### Current Health Condition

Unwanted Condition (Why you are here today?):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please Label On The Diagram The Area Of Discomfort**

Use the letters BELOW to indicate the LOCATION of your sensations right

Key: A=Ache B=Burning N = Numbness  
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has it ever occurred before?  Yes  No.

When? \_\_\_\_\_

Is the Condition:  Auto Related  Job Related  Home Injury

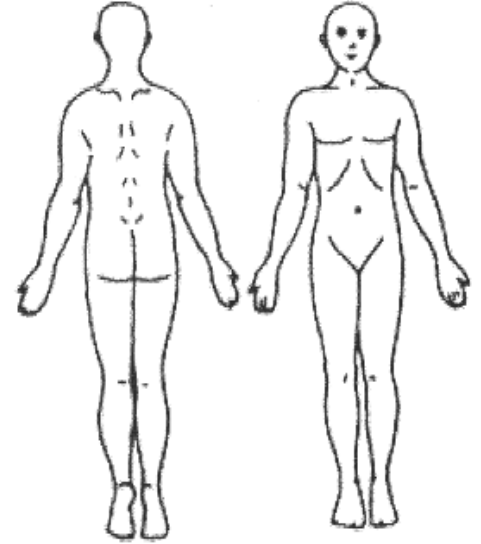
Slip or Fall  Lifting  Slept Wrong  Unknown Cause

Other, please explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am /pm

Condition/Pain STARTED on what Date: \_\_\_\_\_

Do you SUFFER with ANY OTHER condition than which you are now consulting us?



Rate your pain level. 0-10 Scale 0 being no pain, 10 being severe pain.

Active 0 1 2 3 4 5 6 7 8 9 10 Resting 0 1 2 3 4 5 6 7 8 9 10

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_

**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 as the problems can affect your overall course of care.

**Constitutional:**  I DENY having or have had any of the symptoms or problems listed below.

- chills  fatigue  night sweats  weight loss
- daytime drowsiness  fever  weight gain

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness  change in vision  field cuts  photophobia
- blurred vision  double vision  glaucoma  tearing
- cataracts  eye pain  itching  wear glasses/contacts

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding  ear drainage  hearing loss  nosebleeds  sore throat
- dentures  ear pain  history of head injury  postnasal drip  tinnitus (ringing in ears)
- difficulty swallowing  fainting  hoarseness  rhinorrhea (runny nose)  TMJ problems
- discharge  frequent sore throats  loss of sense of smell  sinus infections
- dizziness  headaches  nasal congestion  snoring

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- asthma  coughing up blood  sputum production
- cough  shortness of breath  wheezing

Doctor Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain                        | <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> swelling of legs                              |
| <input type="checkbox"/> claudication (leg pain/ache)      | <input type="checkbox"/> orthopnea (difficulty breathing lying down)                           | <input type="checkbox"/> ulcers  |
| <input type="checkbox"/> heart murmur                      | <input type="checkbox"/> palpitations  | <input type="checkbox"/> varicose veins                                |
| <input type="checkbox"/> heart problems                    | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) |  |

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain       | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> indigestion     | <input type="checkbox"/> abnormal stool caliber     | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching             | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice        | <input type="checkbox"/> abnormal stool color       |   |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn             | <input type="checkbox"/> nausea          | <input type="checkbox"/> abnormal stool consistency |   |
| <input type="checkbox"/> constipation         | <input type="checkbox"/> hemorrhoids           | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting                   |   |

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> birth control     | <input type="checkbox"/> cramps             | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding  |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy              | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy    | <input type="checkbox"/> urine retention        |  |

**Male:**  I DENY having any of the symptoms or problems listed below.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> burning urination    | <input type="checkbox"/> frequent urination   | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention   |

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance   | <input type="checkbox"/> excessive hunger                | <input type="checkbox"/> goiter           | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> excessive thirst                | <input type="checkbox"/> hair loss        | <input type="checkbox"/> voice changes       |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance |  |

**Skin:**  I DENY having any of the symptoms or problems listed below.

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss                 | <input type="checkbox"/> itching      | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color   | <input type="checkbox"/> hives                     | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities          |
| <input type="checkbox"/> hair growth             | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash         |  |

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- |  |  |  |   |  |
|--|--|--|---|--|
| <input type="checkbox"/> dizziness       | <input type="checkbox"/> limb weakness         | <input type="checkbox"/> numbness          | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor                                |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures          | <input type="checkbox"/> stress         | <input type="checkbox"/> unsteadiness of gait/ loss of balance |
| <input type="checkbox"/> headache        | <input type="checkbox"/> loss of memory        | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes        |  |

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- |   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia                  | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety                    | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression  | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion         | <input type="checkbox"/> insomnia    |                                      |

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- |   |   |   |                                   |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis      | <input type="checkbox"/> itching                | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash                     |                                   |

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia   | <input type="checkbox"/> blood clotting    | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue         |  |

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.**

**Previous Care for this Same Condition:**

I have not previously seen a doctor for this condition OR Fill in the information below.

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Was the treatment beneficial in resolving condition?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:  I have not previously seen a Chiropractor OR Fill in the information below.**

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**Current Medication(s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

**Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.**

- |   |  |                                    |   |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD                        | <input type="checkbox"/> chicken pox                 | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis          |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis             | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder   |
| <input type="checkbox"/> allergies/hayfever         | <input type="checkbox"/> depression                  | <input type="checkbox"/> HIV       | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia                     | <input type="checkbox"/> diabetes                    | <input type="checkbox"/> measles   | <input type="checkbox"/> spina bifida       |
| <input type="checkbox"/> asthma                     | <input type="checkbox"/> ear infections              | <input type="checkbox"/> mumps     | <input type="checkbox"/> other:             |
| <input type="checkbox"/> bedwetting                 | <input type="checkbox"/> fetal drug exposure         | <input type="checkbox"/> psoriasis |   |
| <input type="checkbox"/> cerebral palsy             | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash      |   |

**Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD             | <input type="checkbox"/> cystic kidney disease  | <input type="checkbox"/> hypertension                 | <input type="checkbox"/> psychiatric problems             |
| <input type="checkbox"/> alzheimers      | <input type="checkbox"/> depression             | <input type="checkbox"/> influenzal pneumonia         | <input type="checkbox"/> scoliosis                        |
| <input type="checkbox"/> anemia          | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease                | <input type="checkbox"/> seizures                         |
| <input type="checkbox"/> arthritis       | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease                 | <input type="checkbox"/> shingles                         |
| <input type="checkbox"/> asthma          | <input type="checkbox"/> eczema                 | <input type="checkbox"/> lupus erythema (discoid)     | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer          | <input type="checkbox"/> emphysema              | <input type="checkbox"/> lupus erythema (systemic)    | <input type="checkbox"/> STD's (unspecified)              |
| <input type="checkbox"/> cerebral palsy  | <input type="checkbox"/> eye problems           | <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> suicide attempt(s)               |
| <input type="checkbox"/> chicken pox     | <input type="checkbox"/> fibromyalgia           | <input type="checkbox"/> parkinson's disease          | <input type="checkbox"/> thyroid problems                 |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease          | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo                          |
| <input type="checkbox"/> CRPS (RSD)      | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> pneumonia                    | <input type="checkbox"/> other:                           |
| <input type="checkbox"/> CVA (stroke)    | <input type="checkbox"/> HIV                    | <input type="checkbox"/> psoriasis                    |   |

**Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition?  yes or  no.**

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Surgery(ies): List ALL Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> angioplasty             | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy            | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section       | <input type="checkbox"/> dental surgery   | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsilectomy        |
| <input type="checkbox"/> carpal tunnel repair    | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other:              |
| <input type="checkbox"/> coronary artery bypass  | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           |  |

**Injury/Injuries: Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> back injury      | <input type="checkbox"/> head injury (loss of consciousness)    | <input type="checkbox"/> motor vehicle accident        |
| <input type="checkbox"/> broken bones     | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild)     |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident                    | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe)    | <input type="checkbox"/> joint injury                           | <input type="checkbox"/> soft tissue injury (severe)   |
| <input type="checkbox"/> fracture         | <input type="checkbox"/> laceration (severe)                    | <input type="checkbox"/> other:                        |

**Family History: Mark all that apply below. List any specific conditions past or present after "has/had:".**

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_