Horsley
CHIROPRACTIC & PHYSICAL REHABILITATION

CONFIDENTIAL PATIENT HEALTH RECORD

HOW DID YOU HEAR ABOUT US?

DATE: / /

DATE OF BIRTH: / /

PERSONAL INFORMATION

FIRST: MIDDLE: LAST:

☐ MALE ☐ FEMALE AGE:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: CELL PHONE: WORK PHONE:

SOCIAL SECURITY #: / / EMAIL ADDRESS:

EMERGENCY CONTACT NAME: PHONE NUMBER: RELATIONSHIP TO YOU:

PLACE OF WORK: OCCUPATION/JOBTITLE: DESCRIPTION:

WORK ADDRESS: CITY: STATE:

HRS_____ DAY/WEEK

SPOUSE'S NAME: CHILDREN (NAME AND AGES):

PRIMARY CARE PHYSICIAN: PHONE #:

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR YOUR BILL (MARK APPROPRIATE BOX(ES): ☐ SELF ☐ AUTO INSURANCE ☐ WORKER'S COMP ☐ OTHER (BE SPECIFIC)

HEALTH INSURANCE CARRIER: ID#: GROUP#:

POLICY HOLDERS NAME: POLICY HOLDER'S SS# :

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Horsley Chiropractic & Physical Rehabilitation will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Horsley Chiropractic & Physical Rehabilitation will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of Chiropractic Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. In addition, I acknowledge that I have received Horsley Chiropractic & Physical Rehabilitation's notice of privacy practices for protected health information. Furthermore, I authorize Horsley Chiropractic & Physical Rehabilitation to provide my primary care physician with information related to my current condition and treatment program. Finally, I concede that the above information is true and accurate to the best of my knowledge.

Patient Print Name: _____

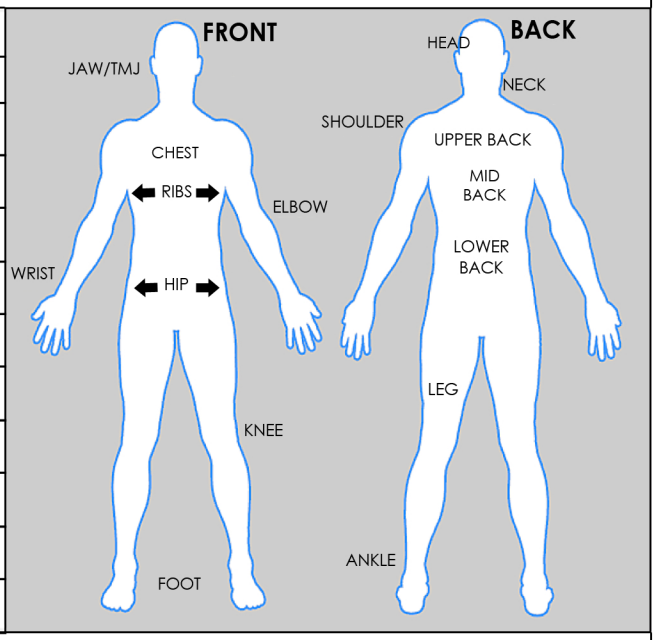
Patient's Signature: _____ Date: _____

If patient is a minor, Guardian or Spouse's Signature of Authorizing Care: _____Date: _____

NAME: **HEIGHT:** **WEIGHT:**

BODY AREAS INVOLVED: (PLEASE CIRCLE ON GRAPH)

DOCTOR'S NOTES



CONDITION: ☐ ACUTE (SIX WEEKS OR LESS) ☐ CHRONIC (SIX WEEKS OR MORE) ☐ RECURRENCE (ACUTE) ☐ EXACERBATION (ACUTE)

HOW DID INJURY OCCUR: ☐ AUTO ☐ WORK INJURY ☐ OVEREXERTION ☐ SLIP/FALL ☐ SLEPT WRONG ☐ LIFTING ☐ FALLING OBJECT REPETITIVE MOTION ☐ NO INJURY ☐ UNKNOWN REASON ☐ OTHER_____

CURRENT SYMPTOMS: ☐ PAIN ☐ NUMBNESS ☐ STIFFNESS ☐ WEAKNESS ☐ OTHER_____

QUALITY: ☐ BURNING ☐ DIFFUSE ☐ DULL/ACHING ☐ LOCALIZED ☐ RADIATING ☐ SHARP ☐ SHOOTING ☐ STABBING ☐ THROBBING ☐ TIGHTNESS ☐ TINGLING ☐ OTHER_____

LEVEL OF IMPAIRMENT DUE TO SYMPTOMS (RESTING):

0 1 2 3 4 5 6 7 8 9 10
(NO PAIN) (EXTREME PAIN)

LEVEL OF IMPAIRMENT DUE TO SYMPTOMS (WITH ACTIVITY):

0 1 2 3 4 5 6 7 8 9 10
(NO PAIN) (EXTREME PAIN)

DURATION: STARTED:_____ LAST OCCURED:_____ WORSENED:_____
INJURY / ACCIDENT OCCURED:

TIMING: ☐ CONSTANT ☐ INTERMITTENT *WORSE IN:* ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ W/ACTIVITY

ASSOCIATED SIGNS AND SYMPTOMS: ☐ BLURRED VISION ☐ DEPRESSION ☐ DIZZINESS ☐ IRRITABILITY/MOOD SWINGS ☐ LOCALIZED TINGLING ☐ NAUSEA ☐ RINGING IN EARS ☐ SLEEP DISTURBANCE ☐ STIFFNESS ☐ HEADACHES

RADIATING PAIN (ie. DOWN ARM(S) AND/OR LEG(S): LEFT / RIGHT / BOTH SIDES DESCRIBE:_____

_____

_____

WEAKNESS: LEFT / RIGHT / BOTH SIDES DESCRIBE:_____

_____

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 (EVEN IF DENY) AS THE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

CONSTITUTIONAL
- ☐ CHILLS
- ☐ DAYTIME DROWSINESS
- ☐ FATIGUE
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

EYES/VISION
- ☐ BLINDNESS
- ☐ BLURRED VISION
- ☐ CATARACTS
- ☐ CHANGE IN VISION
- ☐ DOUBLE VISION
- ☐ EYE PAIN
- ☐ FIELD CUTS
- ☐ GLAUCOMA
- ☐ ITCHING
- ☐ PHOTOPHOBIA
- ☐ TEARING
- ☐ WEAR GLASSES/CONTACTS
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

EARS, NOSE & THROAT
- ☐ BLEEDING
- ☐ DENTURES
- ☐ DIFFICULTY SWALLOWING
- ☐ DISCHARGE
- ☐ DIZZINESS
- ☐ EAR DRAINAGE
- ☐ EAR PAIN
- ☐ FAINTING
- ☐ FREQUENT SORE THROATS
- ☐ HEADACHES
- ☐ HEARING LOSS
- ☐ HISTORY OF HEAD INJURY
- ☐ HOARSENESS
- ☐ LOSS OF SMELL
- ☐ NASAL CONGESTION
- ☐ NOSEBLEEDS
- ☐ POSTNASAL DRIP
- ☐ RHINORRHEA (RUNNY NOSE)
- ☐ SINUS INFECTION
- ☐ SNORING
- ☐ SORE THROAT
- ☐ TINNITUS (RINGING IN EARS)
- ☐ TMJ
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

RESPIRATION
- ☐ ASTHMA
- ☐ COUGH
- ☐ COUGHING UP BLOOD
- ☐ SHORTNESS OF BREATH
- ☐ SPUTUM PRODUCTION
- ☐ WHEEZING
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

CARDIOVASCULAR
- ☐ ANGINA (CHEST PAIN)
- ☐ CHEST PAIN
- ☐ CLAUDICATION (LEG PAIN)
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ ORTHOPNEA (DIFFICULTY W/ BREATHING LYING DOWN)
- ☐ PALPITATIONS
- ☐ WALKING AT NIGHT W/ SHORTNESS OF BREATH (PND)
- ☐ SHORTNESS OF BREATH W/ EXERTION OR EXERCISE
- ☐ SWELLING OF LEG
- ☐ ULCERS
- ☐ VARICOSE VEINS
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ BELCHING
- ☐ BLACK-TARY STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ DIFFICULTY SWALLOWING
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ INDIGESTION
- ☐ JAUNDICE
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ ABNORMAL STOOL CALIBER
- ☐ ABNORMAL STOOL COLOR
- ☐ ABNORMAL STOOL CONSIST
- ☐ VOMITING
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

FEMALE
- ☐ BIRTH CONTROL
- ☐ BREAST LUMPS/PAIN
- ☐ BURNING URINATION
- ☐ CRAMPS
- ☐ FREQUENT URINATION
- ☐ HORMONE THERAPY
- ☐ IRREGULAR MENSTRUATION
- ☐ PREGNANT? WKS_____
- ☐ URINE RETENTION
- ☐ VAGINAL BLEEDING
- ☐ VAGINAL DISCHARGE
- ☐ LAST MENSTRUATION _____
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

MALE
- ☐ BURNING URINATION
- ☐ ERECTILE DISFUNCTION
- ☐ FREQUENT URINATION
- ☐ HESITANCY/DRIBBLING
- ☐ PROSTATE PROBLEMS
- ☐ URINE RETENTION
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

ENDOCRINE
- ☐ COLD INTOLERANCE
- ☐ DIABETES
- ☐ EXCESSIVE APPETITE /HUNGER
- ☐ EXCESSIVE THIRST
- ☐ ABNORMAL FREQUENT URINATION
- ☐ GOITER
- ☐ HAIR LOSS
- ☐ HEAT INTOLERANCE
- ☐ UNUSUAL HAIR GROWTH
- ☐ VOICE CHANGES
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

SKIN
- ☐ CHANGES IN NAIL TEXTURE
- ☐ CHANGES IN SKIN COLOR
- ☐ HAIR GROWTH
- ☐ HAIR LOSS
- ☐ HIVES
- ☐ HISTORY SKIN DISORDERS
- ☐ ITCHING
- ☐ PARESTHESIAS
- ☐ RASH
- ☐ SKIN LESIONS/ULCERS
- ☐ VARICOSITIES
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

NERVOUS SYSTEM
- ☐ DIZZINESS
- ☐ FACIAL WEAKNESS
- ☐ HEADACHE
- ☐ LIMB WEAKNESS
- ☐ LOSS OF CONSCIOUSNESS
- ☐ LOSS OF MEMORY
- ☐ NUMBNESS
- ☐ SEIZURES
- ☐ SLEEP DISTURBANCE
- ☐ SLURRED SPEECH
- ☐ STRESS
- ☐ STROKES
- ☐ TREMOR
- ☐ LOSS OF BLANCE
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

PSYCHOLOGIC
- ☐ ANHEDONIA
- ☐ ANXIETY
- ☐ LOSS/CHANGE APPETITE
- ☐ BEHAVIORAL CHANGE
- ☐ BI-POLAR DISORDER
- ☐ CONFUSION
- ☐ CONVULSIONS
- ☐ DEPRESSION
- ☐ INSOMNIA
- ☐ MEMORY LOSS
- ☐ MOOD CHANGES
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

ALLERGY
- ☐ ANAPHALAXIS
- ☐ FOOD INTOLERANCE
- ☐ ITCHING
- ☐ ACCUTE NASAL CONGEST
- ☐ CHRONIC NASAL
- ☐ RASH
- ☐ SNEEZING
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

HEMATOLOGIC
- ☐ ANEMIA
- ☐ BLEEDING
- ☐ BLOOD CLOTTING
- ☐ BLOOD TRANSFUSION
- ☐ BRUISING EASILY
- ☐ LYMPH NODE SWELLING
- ☐ **I DENY** HAVING ANY OF THE SYMPTOMS OR PROBLEMS ABOVE

DAILY ACTIVITIES: EFFECTS OF CURRENT CONDITION ON PERFORMANCE	
BENDING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
CARRYING GROCERIES	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
CHANGE POSITION - SIT/STAND	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
CLIMB STAIRS	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
DRIVING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
EXTENDED COMPUTER USE	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
HOUSEHOLD CHORES	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
KNEELING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
LIFTING CHILDREN	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
LIFTING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
READING (CONCENTRATION)	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
SELF-CARE (BATHING, DRESSING, SHAVING)	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
SLEEP	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
STATIC SITTING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
STATIC STANDING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
WALKING	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
YARD WORK	☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)

EMPLOYMENT: CONDITION'S EFFECT ON JOB PERFORMANCE
☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)

RECREATIONAL ACTIVITY: EFFECTS OF CURRENT CONDITION ON PERFORMANCE
_____ ☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)
☐NO EFFECT ☐ **MILD** PAINFUL (CAN DO) ☐**MOD** PAINFUL (LIMITED) ☐**SEV** (UNABLE TO PERFORM)

PAST HEALTH HISTORY - FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE

HAVE YOU SEEN OTHER DOCTORS FOR **THIS** CONDITION? ☐YES ☐NO IF YES, WHO?_____
TYPE OF TREATMENT:_____WERE YOU SATISFIED WITH THE RESULTS OF YOUR TREATMENT☐YES ☐NO
EXPLAIN:_____

SURGERIES (LIST ALL SURGICAL PROCEDURES YOU HAVE HAD):

_____
_____

INJURIES (LIST ALL INJURIES YOU HAVE HAD):

_____
_____

DIET ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT

EXERCISE ☐ NEVER ☐ONCE IN A WHILE ☐2X/WEEK ☐3X/WEEK ☐4X/WEEK ☐MORE THAN 4X/WEEK

ALCOHOL ☐ DO NOT DRINK ALCOHOL ☐ SOCIALLY ☐ REGULARLY ***TOBACCO*** ☐ DO NOT USE TOBACCO ☐ DO USE TOBACCO

CURRENT MEDICATION(S): LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING.

MEDICATION	DOSAGE	FOR WHAT CONDITION?	HOW LONG?

LIST ANY OTHER HEALTH CONDITION(S) IE... PACEMAKER, CANCER, MULTIPLE SCLEROSIS, LUNG PROBLEMS, ETC...:

END