



**SUMMIT CHIROPRACTIC
CARE CENTER, L.L.C.**

Confidential Health Record

DATE: _____

Personal Information

Name: _____ Birthdate: _____ Age: _____ Sex: _____

Address: _____ City, ST, Zip _____

Home Phone: _____ Alternate/Cell Phone: _____

Social Security #: ____ - ____ - ____ email address: _____

Circle one: Married Single Separated Divorced Widowed

Number of children and their ages: _____

Type of work/Employer: _____

Name/phone # of Emergency Contact: _____

Relationship: _____

Will you be using health insurance benefits for payment to this office? **YES NO**

If "yes", please provide ID card to us, and initial that you understand that co-pay, co-insurance and/or deductible for services rendered is due today or at time of service in this office. By initialing, you also understand that proof of insurance does not mean that definite out-of or in-network benefits are available and verified. _____

If "no", please initial here that full payment for services rendered today is due by cash, check or MasterCard/Visa/Discover/CareCredit. _____

Whether you answered "yes" or "no" please initial here indicating that you are personally responsible for bills from this office. _____

(Fees, insurance coverage and payment options will be fully explained to you today.)

Referred to this health center by: _____

(Please indicate specific ad/phone book/magazine or person's name if possible.)

Current Health Condition

Location of your pain: _____

Intensity of pain: Please rate your pain from 0-10, 10 being the worst/most intense: ____

How long have you had the pain? _____

What seems to aggravate it/what time of day do you experience it the most?

What seems to alleviate the pain?

Please list any other health care practitioners, doctors, therapists that you have seen in the past 6 months with the reason for the visit/treatment:

Activity Level: Check your current level of work or lifestyle:

- Level 1: Very Light Work:** Sitting, standing, driving, reading, computer, etc.
- Level 2: Light Work:** light housework, labor, childcare, mechanic, some sitting, etc.
- Level 3: Moderate Work:** heavy gardening, housework, labor, no sitting, etc.
- Level 4: Heavy Work:** heavy manual labor, construction, digging, etc.

Exercise Level: Check your current level of exercise:

- NONE**
- Level A-Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- Level B-Moderate Exercise:** 2-3 times/week, moderate pace, some weights, etc.
- Level C-Heavy Exercise:** 3-4 times/week, vigorous pace, weights, fast running, etc.

Sleep Patterns: Check your current sleep pattern (all that apply):

- Level 1:** I sleep during day and work at night
- Level 2:** I have trouble falling asleep and/or I awake at night
- Level 3:** I get about 4-6 hours of sleep on average per night
- Level 4:** I awake very tired/sluggish in the morning no matter what my night was like
- Level 5:** I get about 7-9 hours of sleep per night and feel rested in the morning most of the time

Elimination: Check or answer your current level of elimination:

- I have normal regular bowel movements at least once each day
- I may go 2-3 days between each bowel movement.
- I switch from constipation to diarrhea depending on stress/eating.
- I urinate at least 5-8 times a day.
- I urinate 2-4 times a day.

For Women Only: Please check your female cycle status

- In menopause currently
- Had hysterectomy/still have ovaries: Age at operation ____
- Had hysterectomy/no ovaries: Age at operation ____
- Irregular/uncomfortable periods
- Symptoms indicate peri-menopause (i.e., night sweats, heavy periods, acne, etc)
- I experience moderate-severe PMS
- Pregnant now or MAY BE pregnant
- On hormone replacement therapy: circle: NATURAL or PRESCRIPTION
- On birth control pill/batch or shot now or in the last year

Nutrition/Lifestyle Habits:

- I smoke or chew tobacco
 - o Amount per wk: ____
- I smoke or take recreational drugs
 - o How often? _____
- I drink alcohol:
 - o Wine: #/wk: ____
 - o Beer: #/wk: ____
 - o Cocktails: #/wk: ____
- I drink DIET or ARTIFICIALLY SWEETENED beverages:
 - o Soda: # /wk: ____
 - o Tea: # /wk: ____
 - o Creamers/other: _____
- I drink REGULAR variety of the following beverages:
 - o Gatorade/sport drinks ____
 - o Regular Soda: #/wk ____
- I drink coffee
 - o Decaf: #/wk ____
 - o Regular: #/wk ____
- I drink water
 - o # of 8 oz. glasses/day ____
- I drink milk
 - o Organic: #/wk ____
 - o Non-organic: #/wk ____

Nutrition/Lifestyle Habits, cont'd

- I eat fast-food (drive-thru)
 - o # times/wk and where?

- I eat microwave frozen meals
 - o # times/wk and example

- I chew gum

Stress Level/Goals

- I feel stressed most of the time
 - o Because of work
 - o Because of money
 - o Because of relationships
 - o Because of health
 - o Other
- I would like to reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating illness" orientation to a "creating wellness" lifestyle

Please list ALL prescription and over-the-counter medications you currently take, or have taken in the last 6 months with the reason for the medication:

Please list ALL vitamins/supplements that you currently take:

How much do you weigh? _____ How tall are you? _____

Please check any condition you have experienced :

- Thyroid disorder
- Diabetes
- Insulin Resistance (PRE-diabetes)
- Hypoglycemia
- Sleep disorders
- TMJ (jaw)
- Teeth disorders
- Heart disease/cardiovascular disorders
- Cancer (type _____)
- Reproductive disorders
- Sexual Dysfunction
- High blood pressure
- Arthritis
- Epilepsy/seizures
- Digestive disorders
- Auto-immune disease (type _____)
- Hepatitis
- Please list any surgeries: _____

- OTHER condition/illness disorder (please explain below)

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I also attest that the statements made on this form are true to the best of my knowledge, and I have disclosed the information truthfully and accurately.

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected *and* relieved (CORRECTIVE CARE). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

___ Relief Care ___ Corrective Care ___ I want the Doctor to
select the type of care
appropriate for my condition

Signature _____ Date _____