CATHEY CHIROPRACTIC

Confidential Patient Health Information

Personal Information:

Mr. Mrs. Miss Name: _____

Address: _____City/ST: _____ZIP:_____

SS#: _____/_____/_____ Birthdate: ___ /____/____ Age: _____

Marital Status: M W Sep. D Sin. Spouse Name: _____ No. of Children: _____

Home Phone: ( ) ____-_____ Work Phone: ( ) _____-_____X____ Other Phone ( ) _____-_____

Employer: _____Occupation: _____ How Long? _____

E-mail address (for Patient newsletter):_____

HOW WERE YOU REFERRED?_____

Reason for your Visit:

Purpose of this appointment_____

Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other

Please describe the pain and its location: _____

Date of accident/injury, or when condition began: _____/_____/_____

Is condition getting worse? Yes No Staying the Same Comes and goes

Is this condition interfering with your: Work Sleep Daily Routine Other

Have you been treated by another doctor for this condition? Yes No

If yes, please name doctor/health care facility: _____

Is there any chance that you are pregnant? Yes No Estimated due date: _____

Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

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General	Muscle & Joint	Eyes, Ears Nose & Throat	Gastrointestinal
C P Allergy Problems	C P Arthritis	C P Hearing Loss	C P Colon
C P Convulsions	C P Bursitis	C P Ear-ache	C P Constipation
C P Fatigue	C P Low Back Pain	C P Failing Vision	C P Diarrhea
C P Fainting	C P Neck Pain/Stiffness	C P Nosebleeds	C P Gall Bladder
C P Headache	C P Shoulder Pain	C P Sinus Infections	C P Hemorrhoids
C P Sudden Weight Loss	C P Spinal Curvature	C P Strep Throat	C P Hernia
C P High Blood Pressure	C P Midback Pain	C P Thyroid Problems	C P Liver Problems

Vascular	Pain or Numbness	Skin Problems	Respiratory
C P Nausea/Vomiting	C P Shoulders/Arms	C P Bruise Easily	C P Asthma
C P Dizziness	C P Elbows/Hands	C P Hives or Allergic Reaction	C P Chest Pain
C P Numbness on one side of the face or body	C P Hips/Legs	C P Skin Rash	C P Chronic Cough
	C P Ankles/Knees/Feet	C P Acne	C P Spitting up
Blood			
C P Difficulty Swallowing			

	Genito-Urinary	For Women Only	Other
C P Difficulty Walking	C P Bedwetting	C P Cramps or Backache w/cycle	C P Stroke
C P Difficulty Speaking	C P Frequent Urination	C P Excessive Menstral Flow	C P Rheum.Fever
C P Fainting/Light Headed	C P Kidney Infection	C P Irregular Cycles	C HIV/AIDS
C P Double Vision	C P Painful Urination	C P Lumps in Breast	C P Alcoholism
C P Rapid Eye Movement	C P Prostate Trouble	C P Pelvic Inflammatory Disease	C P Diabetes
C P Neck or Head Pain	C P Kidney Stones		C P Cancer

Please list any medications you are taking, (including OTC)_____

Please list any medications that you are allergic to: _____

Please list all surgeries and dates_____

_____

Medical Physician's name_____

Your Family History (some health problems are the result of familial tendencies)

Illnesses

Father_____
Mother_____
Brother(s)_____
Sister(s)_____

Social History

Do you smoke? Yes No If yes, how may packs per day? _____ For how long?_____
Do you consume alcoholic beverages? Yes No If yes, socially? Moderately? Daily? Rarely?
Do you exercise regularly? Yes No If yes, daily? 3x/week 1x/week Other (specify): _____

In the event of an emergency…

Who should we contact? _____ Relationship: _____

Home Phone #: ( ) _____-_____ Work Phone #: ( ) _____-_____ X _____

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