Patient Health Record

Date _____

Name _____

Age_____ Date of Birth_____

Address _____Apt# _____

City _____ State _____ Zip _____

Phone _____

Email _____

Insurance _____ID #_____

Emergency Contact Name and Number: _____

_____

Height _____ Weight _____ Handedness ☐ R ☐ L

Marital Status ☐ M ☐ S ☐ W ☐ D # of children _____

Employment ☐FT ☐PT ☐UN ☐Retired ☐Student

Employer _____ Type of Work _____

What is your physical activity at work?

☐Heavy ☐Light ☐Sitting (more than 50%)
☐Combination

Who referred you this office?

_____

Have you been to a chiropractor before? ☐ Yes ☐ No

Approximate date and reason for last visit

_____

_____

Was it helpful? ☐ Yes ☐ No _____

_____

_____

Describe the reason for this visit

_____

_____

_____

Is this visit related to:

☐Exercise/Sports ☐Home Injury ☐Wellness

☐Please explain _____

Rate your pain from 1-10 (10 = worst) _____

Does the pain travel? ☐Y ☐N

Please explain _____

When did this condition begin? _____

Has this condition: ☐ stayed constant ☐ frequent

☐ comes and goes ☐ gotten worse

Has this condition occurred before? ☐Yes ☐No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's specialty _____

Type of treatment _____

Results _____

Describe previous MRI/X-ray results _____

_____

_____

_____

	Yes	No
Do you smoke?	☐	☐
Do you drink alcohol/drugs?	☐	☐
Is your diet generally healthy?	☐	☐

What type of regular exercise do you perform?

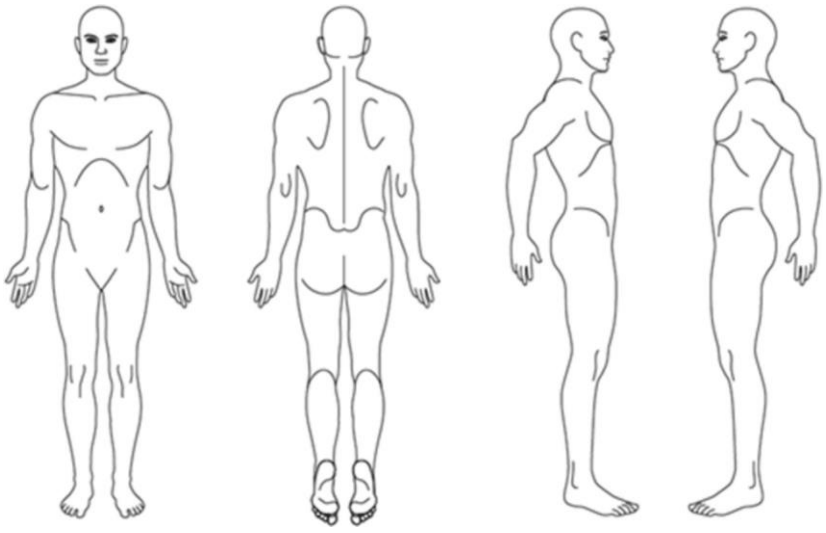
☐ None ☐ Light ☐ Moderate ☐ Strenuous

Please Describe: _____

_____

Perline Chiropractic PC
212-371-0700
perlinechiropractic@gmail.com
135 East 50th St, Ste 102, NYC 10022
100 North Centre Ave, Ste 202, RVC NY 11570

Please Mark the Area(s) Of Concern



☐ Throbbing ☐ Aching ☐Stiffness

☐ Shooting ☐ Cramping ☐ Burning

☐ Tingling ☐ Swelling ☐ Numbness

☐ Dull ☐ Radiating ☐ Sharp

☐ Extreme Tightness

Pain worse in the ☐ AM ☐ PM

Pain worse with ☐sitting ☐standing ☐walking

☐ Other _____

_____

WOMEN:

Are you pregnant? ☐ Yes ☐ No How may weeks? _____

If YES, is this your first pregnancy? ☐ Yes ☐ No

Are you having a ☐ Boy ☐Girl ☐Twins ☐ Don't Know

Please describe your previous births _____

_____

Have you experienced any complications during this pregnancy? _____

If you are here today with pain, do you believe it is due to your pregnancy? ☐ Yes ☐ No

Please explain _____

_____

WOMEN:

Are you nursing? ☐ Yes ☐ No

Do you experience painful periods?

☐ Yes ☐No Please explain _____

_____

Is your low back pain worse with your period? ☐ Yes ☐No _____

Do you have breast implants?

☐ Yes ☐ No _____

Please check all that apply:

☐Sinus problems ☐Dizziness ☐Depression/Anxiety ☐High/Low blood pressure

☐New Clumsiness ☐Asthma ☐Neck/Back problems ☐Difficulty breathing

☐Alcohol/drug abuse ☐Ulcers/Colitis ☐Loss of sleep ☐Kidney problems

☐Diabetes/Gestational ☐Thyroid problems ☐Digestive problems _____

☐Groin numbness/pain _____ ☐Weight gain/loss _____

☐Scoliosis – ☐Mild ☐Medium ☐Severe _____

☐Prior illness, surgeries, injuries _____

☐Heart Condition - please explain _____

☐Severe or frequent headaches – please explain _____

☐Cancer – please explain _____

☐Arthritis +/or herniated discs – please explain _____

☐Autoimmune – please explain _____

☐Other – please explain _____

General stress level ☐ low ☐Moderate ☐Severe Please explain _____

Authorizations

We do not offer to diagnose or treat conditions other than vertebral subluxation (spinal misalignments). A vertebral subluxation can cause pain or alteration of nerve function and interference of the transmission of nerve impulses. If during the course of your chiropractic care, we encounter non-chiropractic findings, we will refer you to the appropriate provider.

I understand the doctor's objectives pertaining to my care in this office and accept chiropractic care on this basis.

Protecting the privacy of your personal health information is important. Disclosure of your health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosure for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. A complete description can be made available to me upon request.

I authorize the release of any medical information necessary to process my insurance claims.

I understand that my insurance is an agreement between my insurance company and myself and all services rendered to me in this office are my responsibility. I understand that if I suspend or terminate my care, any fees for services rendered me will become immediately due and payable. I authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I authorize this office to communicate with me and/or send reminders through text, email and phone.

Patient Name (Printed) _____

Patient Signature _____

Date _____

Parent/Guardian/Signing on behalf of patient (Printed) _____

Parent/Guardian/Signing on behalf of patient Signature _____

Relationship to patient _____