Patient Health Record

Date ___________________

Name ____

Birth Date _______________________Age ____________

Address __________________________Apt# __________

City __________________ State _____ Zip ____________

Phone ______________________________________

Email ____

Insurance ____________________________________

Are you the primary insured? ☐ Yes ☐ No

If no, who is? ________________________________

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 ______________________

____

____

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

Describe the reason for this visit

____

____

____

Is this visit related to:

☐Exercise/Sports ☐Home Injury ☐Wellness ☐Job ☐Auto

☐Other ____

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

Does the pain travel? ☐Y ☐N

Please explain __________________________________

When did this condition begin? ____________________

Has this condition:

☐ gotten worse ☐ stayed constant ☐ comes and goes

Does this condition interfere with:

☐Work ☐ Sleep ☐Daily Routine ☐Other Activities

____

Has this condition occurred before? ☐Yes ☐No

Please explain __________________________________

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

Doctor's Name (s) ______________________________

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: ______________________________

WOMEN:

Are you nursing? ☐ Yes ☐ No

Do you experience painful periods?

☐ Yes ☐No Please explain ____________

____

Do you have breast implants?

☐ Yes ☐ No ________________________

WOMEN:

Are you pregnant? ☐ Yes ☐ No

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

How many weeks pregnant are you? ___________________

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

Please describe your previous births ____________________

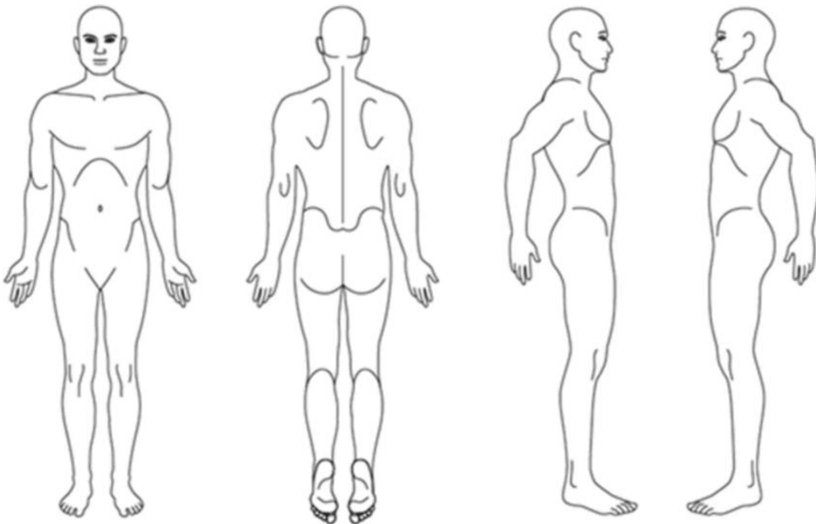
____

____

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

Please explain _____________________________________

Please Mark the Area(s) Of Concern:



☐ Throbbing ☐ Aching ☐Stiffness

☐ Shooting ☐ Cramps ☐ Burning

☐ Tingling ☐ Swelling ☐ Numbness

☐ Dull ☐ Radiating ☐ Sharp

☐ Extreme Tightness

Pain worse in the ☐ AM ☐ PM

Pain worse with ☐sitting ☐standing ☐walking ☐ Other _________________________________

____

Please check all that apply:

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

☐Weight gain/loss ☐Asthma ☐Neck/Back problems ☐Scoliosis

☐Difficulty breathing ☐Alcohol/drug abuse ☐Rheumatic fever ☐HIV/AIDS

☐Ulcers/Colitis ☐Loss of sleep ☐Kidney problems ☐Diabetes/Gestational

☐Thyroid problems ☐Digestive problems ___________________________________ ☐COVID - 19 date(s)______

☐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 ____

Family health history (diabetes, cancer, heart disease) ____

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 ____