PATIENT HEALTH RECORD

ABOUT THE PATIENT

Today's Date: _____/_____/_____

Name _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Birth Date _____ Age _____ Handed R L

Height _____ Weight _____ Marital Status M S W D

Spouse is a patient in the office Y N # of children _____

Employment: Full Time Part Time Unemployed Retired Student

Employer _____ Type of Work _____

Work address _____ Work Phone _____

What is your physical activity at work?

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

EMERGENCY CONTACT

Name _____

Address if different _____

Cell Phone _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Chiropractor's name? _____

Reason for those visits? _____

Approximate date of last chiropractic visit _____

Has any adult in your family seen a Chiropractor? ☐ Yes ☐ No

Has any child in your family seen a Chiropractor? ☐ Yes ☐ No

Perline Chiropractic
212-371-0700
920 3rd Ave, 6th Fl, NYC 10022
119 N Park Ave, Ste 301, RVC, N 11570

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is this visit related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall ☐ Wellness

☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

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

Does the pain travel? ☐ Yes ☐ No
From where to where?

_____

If job related, have you made a report of your accident to your employer?

☐ Yes ☐ No

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

Please explain _____

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 MRI/X-ray results _____

HEALTH HABITS

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

What type of regular exercise do you perform?

☐ None ☐ Light ☐ Moderate ☐ Strenuous

Please Describe _____

AWARENESS OF THE CHIROPRACTIC PRINCIPLES

Were you aware that:

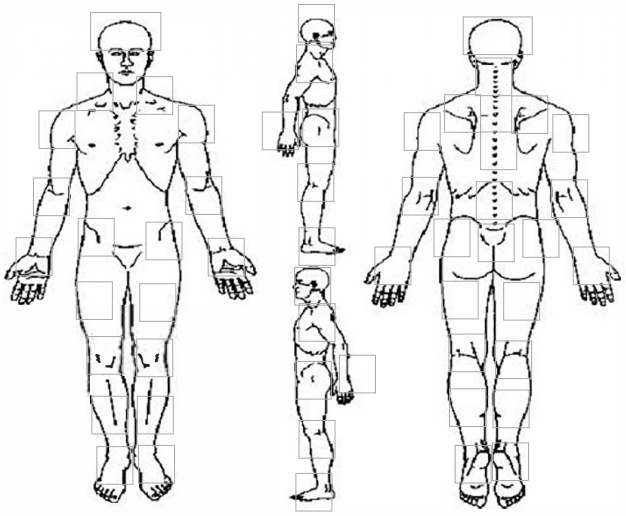
Doctors of Chiropractic work with the nervous system?	☐ Yes	☐ No
The nervous system controls all bodily functions and systems?	☐ Yes	☐ No
Chiropractic is the largest natural healing profession in the world?	☐ Yes	☐ No
Chiropractic is safe and effective for children and pregnant women?	☐ Yes	☐ No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Relief care** – Symptomatic relief of pain or discomfort
- ☐ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptom
- ☐ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- ☐ **I want the Doctor to select the type of care appropriate for my condition.**

Please 'Mark' The Area(s) Of Concern



- ☐ Throbbing
- ☐ Aching
- ☐ Stiffness
- ☐ Sharp
- ☐ Shooting
- ☐ Cramps
- ☐ Dull
- ☐ Burning
- ☐ Tingling
- ☐ Numbness
- ☐ Swelling
- ☐ Extreme Tightness

MEDICATIONS I NOW TAKE...

- ☐ Cholesterol Medication
- ☐ Blood Pressure Medication
- ☐ Stimulants
- ☐ Blood Thinners
- ☐ Sleep Aids
- ☐ Pain killers (including aspirin)
- ☐ Muscle Relaxers
- ☐ Antidepressants/Antianxiety
- ☐ Insulin
- ☐ Hormonal Replacement

Vitamins & Supplements I now take:_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

For women:

Are you pregnant?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No
Do you experience painful periods?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No
Do you have breast implants?	☐ Yes	☐ No
Are you still getting your period?	☐ Yes	☐ No
Did you or are you experiencing back and/or leg pain during your pregnancy?	☐ Yes	☐ No

- ☐ Severe or frequent headaches
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Loss of sleep
- ☐ Depression/Anxiety
- ☐ High/Low blood pressure
- ☐ Unexplained weight gain/loss
- ☐ Numbness in Arms/legs/hands
- ☐ Asthma
- ☐ Lower back problems
- ☐ Digestive problems
- ☐ Heart surgery/pacemaker
- ☐ Heart attack/stroke
- ☐ Heart murmur
- ☐ Congenital heart defect
- ☐ Cancer_____
- ☐ Chemotherapy
- ☐ Difficulty breathing
- ☐ Alcohol/drug abuse
- ☐ Rheumatic fever
- ☐ HIV/AIDS
- ☐ Ulcers/Colitis
- ☐ Arthritis
- ☐ Shingles
- ☐ Kidney problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ COVID19 date: _____

Other:_____

_____

_____

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Patient Health Record Continued

Are there any associated symptoms (headaches, muscle weakness/spasm) _____

_____

Are there any aggravating factors that you are aware of (scoliosis, arthritis, herniated discs) _____

_____

Please describe any prior illnesses, surgeries, injuries _____

_____

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

How would you grade your general stress level (circle one) ☐ Low ☐ Moderate ☐ Severe
Please explain _____

Please include anything you think might help us to better understand your condition _____

Authorizations

We do not offer to diagnose or treat conditions other than vertebral subluxations (spinal misalignments). A vertebral subluxation can cause pain or alteration of nerve function and interference of the transmission of nerve impulses. However, if during the course of your chiropractic care, we encounter non-chiropractic findings, we will recommend you seek the services of a health care provider who specializes in that area.

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 to us. 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 disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

I understand that, under the 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.

All accounts not paid within 60 days will *automatically* be put through on your credit card.

Credit Card # _____ Exp. Date_____ CVV_____

Patient Name (Printed) _____

Patient Signature _____ Date _____