Paul D. Ralph, DC

Confidential Patient Health Record

PATIENT INFORMATION:

Name: Last ________________________ First _____________________ MI ____ Home Phone: (____)___________

Address: _______________________________ City ________________________ State _____ ZIP _____________

Cell Phone: (____)_______________ Email Address ____

Social Security # _______________________ Age ______ Birth Date ___/___/___ Sex _____ Marital Status _______

Your Employer ____________________________City/State_____________________Wk Phone (____)____________

Type of Work ____

Name of Spouse____ Spouse Employer ___________________________

Name/Relationship of Emergency Contact _____________________________________ Phone (____)_____________

Who referred you to our office? ____

CURRENT HEALTH CONDITION:

Please explain the condition you are seeking care for (type of pain, location, severity, etc)

____

Previous Chiro Care: YES / NO Dr. ____________________ Other Doctors Seen: _________________________

Type of treatment: ____ Results __________________________________

When did this condition begin? ____________________ Has it happened before? _________ When? ______________

Is this condition: Job Related / Auto Related / Home Injury / Fall / Other ____________________________

Please list any medication you are taking now: Blood Pressure / Pain Meds / Muscle Relaxers / Aspirin /

Antidepressants/Antiaxiety / Insulin / Others

____

Do you suffer from any condition other than that which you are consulting our office? ___________________________

PAST HEALTH HISTORY:

Major Surgery**:** Appendectomy / Tonsillectomy / Gall Bladder / Back Surgery / Other ______________________

Broken Bones: ____

Major Accidents or Falls: ____

Hospitalizations: (other than above) ____

Patient Signature: ____ Date: ____________________________

Below is a list of conditions relative to your overall health status. Although they may seem unrelated to the purpose of your appointment, such conditions may affect your overall diagnosis and treatment. Please consider these conditions carefully and explain the details of any conditions for which you have checked "yes".

MUSCLE/JOINT:
Have you had any problems with the joints of your arms or legs such as pain, numbness, stiffness, joint noise, or arthritis of bursitis? Yes No **Explain:** ______________________________

RESPIRATORY:
Have you had any problems with shortness of breath, chest or rib pain when breathing, chronic cough, asthma, or bronchitis?
Yes No **Explain**:______________________________

SKIN:
Have you had problems with skin dryness, psoriasis, eczema, itching, rash, hives, excessive sweating or "sensitive" skin?
Yes No **Explain**:______________________________

NERVOUS:
Have you had pain, numbness, tingling, or other altered sensations of any part of your body, or have you ever suffered from chronic headaches, nervousness, dizziness or psychological disorder? Yes No
Explain:______________________________

GASTRO-INTESTINAL:
Have you had any disorders of the stomach or bowel such as pain, excessive gas, chronic diarrhea, nausea, vomiting, or reflux?
Yes No **Explain**:______________________________

GENITO-URINARY:
Have you ever had trouble with your kidneys or bladder such as chronic infection, pain, frequent urination, difficulty urinating, or discharge?
Yes No **Explain**:______________________________

CARDIOVASCULAR:
Have you had problems with blood pressure, chest pain, cholesterol problems, poor circulation, or heart rate or rhythm problems? Yes No **Explain**:______________________________

EARS/EYES/NOSE/THROAT:
Have you had problems with earache, sinus pain, sore throat, eye pain or visual disturbance, or discharge of the eyes, ears or nose?
Yes No **Explain**:______________________________

Do you suffer from any other conditions not mentioned above? Yes No
Explain:______________________________

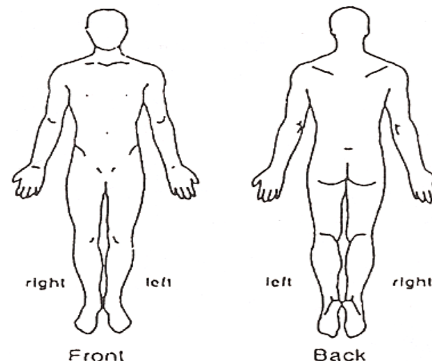
WOMEN ONLY: Have you had problems with your menstrual cycle, vaginal discharge or bleeding, hot flashes, swollen, painful breasts, or discharge from the nipples or other "female" conditions? Yes No
Explain:______________________________

Are you pregnant? Yes No If yes, pregnancy in weeks? _____ Number of children & their ages:_____/_____________

** Please mark all areas of pain by placing the appropriate letter from the list below, in the area of the body you are having pain. **

Aching **B**urning **C**ramping **D**ull

Sharp **N**umbness **T**ingling **O**ther



I HEREBY ACKNOWLEDGE AND ATTEST TO THE INFORMATION OF THIS FORM AS BEING ACCURATE, COMPLETE, AND UNDEVIATING. THROUGH MY SIGNATURE BELOW I HEREBY GIVE PERMISSION TO THE DOCTOR(S) TO PERFORM THE PROCEDURES WHICH ARE DETERMINED TO BE NECESSARY IN THE DIAGNOSIS AND TREATMENT OF MY CONDITION.

Patient Signature: ______________________________ Date: ____________________