Confidential Patient Health Record

***Today's Date*:___/____/_____**

Personal Information

Title: □ Mr. □ Ms. □ Miss □ Mrs.

Last:_____ First:_____ Middle: _____Suffix: □ Jr □ Sr □ II □ III

Birth Date: ____ /____/_____ Age: _____ Sex: Male / Female SSN: _____

Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____ Email Address: _____

I give permission to be contacted in the following manner (check all that apply) _____ Home Phone _____ Cell Phone ____ By Mail_____

Can we send you an appointment reminder/ messages through text message? _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated Spouse Name_____ # of Children :_____

Whom may we thank for referring you?_____

Emergency Contact

Last:_____ First:_____Relationship to Patient:_____Phone Number:_____

Employment Information:

Employer/ School Name: _____ _____Phone: (_____) _____-_____

Address:_____ Occupation/Job Title: _____

Insurance Information:

Who is responsible for this account?_____ Relationship to patient_____

Insurance Carrier: _____ ID #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____-_____-_____ Primary Care Physician: _____

Policy Holder Employer:_____ Employers Address and Phone #:_____

Is this a work related injury? _____ Is this injury related to an auto accident? _____

(If you answered YES to the above questions, stop here and inform the front desk of your work or auto injury)* If you answered NO to the above question, we cannot bill today's service under a work or auto injury claim at a future date.

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with_____(Name of Insurance Co) And assign directly to Dr. Jeffrey Bova all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Jeffrey Bova may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date **Relationship to Patient**

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

SECTION I

Circle Left(L), Right(R), or Both (L/R)

Symptom	Pain	Numb	Tingling	Stiff	Sore	Weak
Head	L R B	L R B	L R B	L R B	L R B	L R B
Neck	L R B	L R B	L R B	L R B	L R B	L R B
Upr Back	L R B	L R B	L R B	L R B	L R B	L R B
Mid Back	L R B	L R B	L R B	L R B	L R B	L R B
Low Back	L R B	L R B	L R B	L R B	L R B	L R B
Shoulder	L R B	L R B	L R B	L R B	L R B	L R B
Elbow	L R B	L R B	L R B	L R B	L R B	L R B
Wrist	L R B	L R B	L R B	L R B	L R B	L R B
Hand	L R B	L R B	L R B	L R B	L R B	L R B
Hip	L R B	L R B	L R B	L R B	L R B	L R B
Knee	L R B	L R B	L R B	L R B	L R B	L R B
Foot	L R B	L R B	L R B	L R B	L R B	L R B
Other	L R B	L R B	L R B	L R B	L R B	L R B

Prognosis:
- ☐ Improving
- ☐ Worsening
- ☐ Unchanged
- ☐ Resolved

Frequency:
- ☐ Occasional (0%-25%)
- ☐ Intermittent (26%-50%)
- ☐ Frequent (51%-75%)
- ☐ Constant (76%-100%)

If symptoms change, when are they worse
- ☐ Morning ☐ Evening
- ☐ Afternoon ☐ Night
- ☐ Other:_____

Type(s) of Pain:
- ☐ Burning
- ☐ Dull/Ache
- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing

Intensity:
- ☐ Mild
- ☐ Moderate
- ☐ Severe

SECTION II

My pain when it is at its worst is:

No Pain>>>>>>>>>>>>>>>>Worst Pain

0 1 2 3 4 5 6 7 8 9 10

My Pain right now is:

No Pain>>>>>>>>>>>>>>>>Worst Pain

0 1 2 3 4 5 6 7 8 9 10

My average Pain level is:

No Pain>>>>>>>>>>>>>>>>Worst Pain

0 1 2 3 4 5 6 7 8 9 10

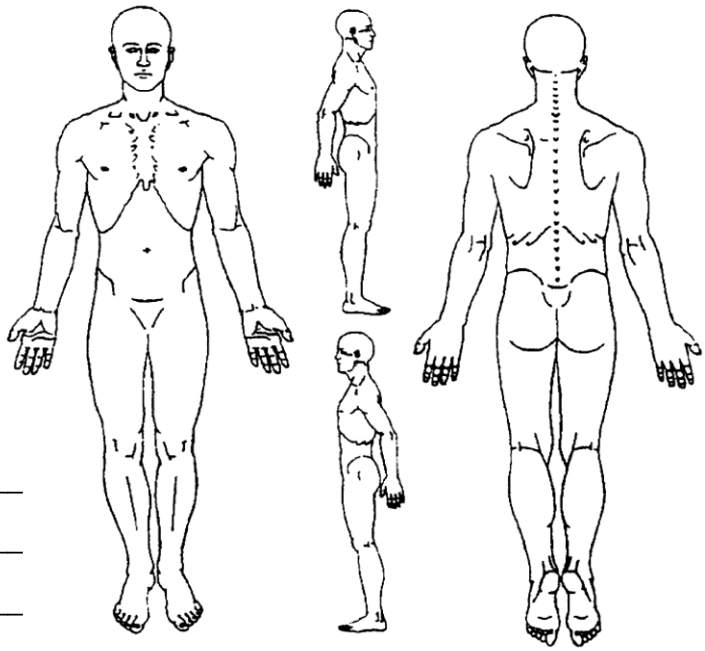
In detail please:

_____

_____

_____

Please mark the pain diagram for the location and type of pain



A=Ache
B=Burning
N=Numbness
S=Sharp/Shooting
T=Throbbing
X=Stinging
O=Other:_____
_____
_____

When did symptoms first appear_____

Does it interfere with your ____ Work ____ Sleep _____ Daily Routine _____ Recreation
Activities or movements that are painful to perform _____ Sitting _____ Standing _____ Walking ____
_____ Bending _____ Lying Down

Patient's Name _____Patient's Signature _____Date _____

PLEASE PRINT

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Chiropractic Care: ☐ **I have not previously seen a Chiropractor OR Fill in the information BELOW.**

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Allergies: List ANY/ALL allergies and reaction: **_____**

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD	☐ chicken pox	☐ headaches	☐ scoliosis
☐ atopic dermatitis (eczema)	☐ crohn's/colitis	☐ hepatitis	☐ seizure disorder
☐ allergies/hayfever	☐ depression	☐ HIV	☐ sickle cell anemia
☐ anemia	☐ diabetes	☐ measles	☐ spina bifida
☐ asthma	☐ ear infections	☐ mumps	☐ other:
☐ bedwetting	☐ fetal drug exposure	☐ psoriasis	
☐ cerebral palsy	☐ food allergies (list below)	☐ rash	

Adult Illness(es): **LIST all health conditions. CIRCLE all CURRENT conditions.**

☐ ADD	☐ cystic kidney disease	☐ hypertension	☐ psychiatric problems
☐ Alzheimer's	☐ depression	☐ influenza pneumonia	☐ scoliosis
☐ anemia	☐ diabetes (insulin dep)	☐ liver disease	☐ seizures
☐ arthritis	☐ diabetes (non insulin)	☐ lung disease	☐ shingles
☐ asthma	☐ eczema	☐ lupus erythema (discoid)	☐ past history of similar symptoms
☐ cancer	☐ emphysema	☐ lupus erythema (systemic)	☐ STD's (unspecified)
☐ cerebral palsy	☐ eye problems	☐ multiple sclerosis	☐ suicide attempt(s)
☐ chicken pox	☐ fibromyalgia	☐ Parkinson's disease	☐ thyroid problems
☐ crohn's/colitis	☐ heart disease	☐ unspecified pleural effusion	☐ vertigo
☐ CRPS (RSD)	☐ hepatitis	☐ pneumonia	☐ other:
☐ CVA (stroke)	☐ HIV	☐ psoriasis	

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

☐ angioplasty	☐ cosmetic	☐ hysterectomy	☐ pacemaker insertion
☐ appendectomy	☐ D & C	☐ joint reconstruction	☐ rotator cuff
☐ caesarian section	☐ dental surgery	☐ joint replacement	☐ spinal fusion
☐ cardiac catheterization	☐ gall bladder	☐ knee repair	☐ tonsilectomy
☐ carpal tunnel repair	☐ hemorrhoidectomy	☐ laminectomy	☐ other:
☐ coronary artery bypass	☐ hernia repair	☐ mastectomy	

Family Health History:

Hereditary conditions/ Family health issues: _____

Personal/Social History:

Living Situation: _____ Occupation/Hours:_____

Stress Factors: _____ Diet (rate: good, fair, poor) _____

Exercise/interests (activities/frequency) _____Habits (alcohol, tobacco, recreational drugs) _____

Bowel Habits (frequency/changes) _____Urinary Habits (changes/problems)_____