

# Cedar Chiropractic

77 West Main Street, Suite 205 • Hopkinton, MA 01748  
p. (508)435-8182 f. (508)435-8183

## PROTECTED HEALTH INFORMATION (PHI)

Thank you for choosing our practice for your healthcare needs. If you ever have any questions or concerns, don't hesitate to ask. We are always happy to help!

### 1. Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
( ) Male ( ) Female Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Ethnicity \_\_\_\_\_  
Are you: ( ) minor ( ) single ( ) married ( ) divorced ( ) widowed E-Mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

### 2. Insurance Information

Will insurance be involved? ( ) YES ( ) NO  
If YES, Are we billing: ( ) Health Insurance ( ) Auto Insurance ( ) Worker's Compensation

### 3. Why Are You Here Today?

Current Illness/Injury \_\_\_\_\_ How did it happen? \_\_\_\_\_  
When did you first notice these symptoms? \_\_\_\_\_ Have you had these symptoms before? Y  
N

Do symptoms include:

( ) neck pain	( ) headaches	( ) irritability	( ) fatigue
( ) neck stiffness	( ) leg/Hip pain	( ) sleep difficulty	( ) dizziness
( ) arm/shoulder pain	( ) shortness of breath	( ) upset stomach	( ) chest pain
( ) hand/finger numbness	( ) memory loss	( ) feet/toe numbness	( ) tension
( ) back stiffness	( ) visual problems	( ) jaw problems	( ) back pain
( ) nausea/vomiting	( ) ears buzzing/ringing	( ) OTHER _____	

What makes your symptoms: better? \_\_\_\_\_  
worse? \_\_\_\_\_

Are these symptoms constant? ( ) YES ( ) NO if NO, how often? \_\_\_\_\_

What type of pain:

( ) sharp	( ) dull	( ) burning	( ) cramping	( ) tingling
( ) aching	( ) shooting	( ) swelling	( ) throbbing	( ) OTHER _____

Does the pain interfere with:

( ) work	( ) sleep	( ) walking	( ) daily/recreation activities
( ) sitting	( ) bending	( ) standing	( ) lying down

Have you received any of the following for your symptoms:

( ) medication ( ) surgery ( ) physical therapy ( ) OTHER \_\_\_\_\_

If YES, From who? \_\_\_\_\_

How much time have you missed from work? \_\_\_\_\_

### 4. Health History

**A. Check off anything that you have now or have had in the past:**

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> diabetes	<input type="checkbox"/> lung disease	<input type="checkbox"/> psychiatric care
<input type="checkbox"/> alcoholism	<input type="checkbox"/> eating disorder	<input type="checkbox"/> lupus	<input type="checkbox"/> rheumatoid arthritis
<input type="checkbox"/> allergies	<input type="checkbox"/> epilepsy	<input type="checkbox"/> measles	<input type="checkbox"/> rheumatic fever
<input type="checkbox"/> anemia	<input type="checkbox"/> eye disorder	<input type="checkbox"/> migraines	<input type="checkbox"/> scarlet fever
<input type="checkbox"/> appendicitis	<input type="checkbox"/> bone fracture	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> STD
<input type="checkbox"/> arthritis	<input type="checkbox"/> goiter	<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> stroke
<input type="checkbox"/> asthma	<input type="checkbox"/> gout	<input type="checkbox"/> mumps	<input type="checkbox"/> suicide attempt
<input type="checkbox"/> bi-polar disorder	<input type="checkbox"/> heart disease	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> thyroid problem
<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> hepatitis	<input type="checkbox"/> pacemaker	<input type="checkbox"/> tonsillitis
<input type="checkbox"/> breast lump	<input type="checkbox"/> hernia	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> cancer	<input type="checkbox"/> herniated disc	<input type="checkbox"/> pinched nerve	<input type="checkbox"/> tumors/growths
<input type="checkbox"/> chemical dependency	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> polio	<input type="checkbox"/> typhoid fever
<input type="checkbox"/> chicken pox	<input type="checkbox"/> kidney disease	<input type="checkbox"/> prostate problem	<input type="checkbox"/> ulcer
<input type="checkbox"/> depression	<input type="checkbox"/> liver disease	<input type="checkbox"/> prosthesis	<input type="checkbox"/> whooping cough
<input type="checkbox"/> OTHER _____			

**B. Have you ever had:**

<input type="checkbox"/> Auto Accident:	how many _____	when _____	did symptoms resolve? ( ) YES ( ) NO
<input type="checkbox"/> slip-and-fall:	how many _____	when _____	did symptoms resolve? ( ) YES ( ) NO
<input type="checkbox"/> surgery:	how many _____	when _____	did symptoms resolve? ( ) YES ( ) NO
<input type="checkbox"/> fractures/dislocations:	how many _____	when _____	did symptoms resolve? ( ) YES ( ) NO
<input type="checkbox"/> hospitalizations:	how many _____	when _____	what for? _____
<input type="checkbox"/> plastic surgery	how many _____	when _____	what for? _____

**C. Family History**

<input type="checkbox"/> cancer: who? _____	<input type="checkbox"/> diabetes: who? _____
<input type="checkbox"/> stroke: who? _____	<input type="checkbox"/> heart disease: who? _____
<input type="checkbox"/> OTHER _____	who? _____

**D. Primary Care**

Primary Doctor name and phone # \_\_\_\_\_ Last complete physical \_\_\_\_\_  
\*WOMEN ONLY- Date of last PAP exam \_\_\_\_\_ Are you pregnant? ( ) YES ( ) NO  
Are you nursing? ( ) YES ( ) NO Are you taking birth-control pills? ( ) YES ( ) NO

**5. Daily Habits**

What type of exercise do you do on a normal basis? \_\_\_\_\_  
What do your daily work habits include? \_\_\_\_\_  
Do you: smoke? ( ) Y ( ) N drink alcohol? ( ) Y ( ) N caffeinated beverages? ( ) Y ( ) N  
How much water do you consume on a daily basis \_\_\_\_\_  
Do you take any vitamins/OTCs/prescription medications? \_\_\_\_\_  
Do you sleep on your: ( ) back ( ) stomach ( ) side Age/type of mattress \_\_\_\_\_

**I certify that the above information is true and factual to the best of my knowledge. I understand that providing incorrect information may be dangerous to my health.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_