

Confidential Patient Health Record

Today's Date: ___ / ___ / ___

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Miss Prof. other: _____

Last: _____ **First:** _____ **Middle:** _____

Suffix: Jr Sr II III MD PhD DO Esq PA RN BSN other: _____

Birth Date: ___ / ___ / ___ **Age:** _____ **Sex:** Male / Female **Social Security #:** _____ - _____ - _____

Primary Language: English French German Spanish other: _____

Driver's License #: _____ **State:** _____

Blood Type: A positive A negative B positive B negative AB positive AB negative O positive O negative

Race: African American Asian Caucasian Hispanic Multiracial Native American Other: _____

Marital Status: Single Married Widowed Divorced Separated

Eye Color: blue brown green grey hazel other: _____

Hair Color: black blonde brown gray red white other: _____

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

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

Cell Phone: (_____) _____ - _____ **ext** _____ **Fax #:** (_____) _____ - _____ **ext** _____

Email Address: _____ **Spouses Name:** _____

Children (Names and Ages): _____

Emergency Contact

Title: Miss Mrs. Ms. Master Mr. Dr. Prof. Rev. other: _____

Last: _____ **First:** _____ **Middle:** _____

Suffix: Jr Sr II III MD PhD DO Esq PA RN BSN other: _____

Address: _____ **Apt #** _____

City: _____ **State:** _____ **Zip:** _____ **Country:** _____ **County:** _____

Relationship: Spouse Relative Friend Other _____

Email Address: _____

Birth Date: ___ / ___ / ___ **Social Security #:** _____ - _____ - _____

Home Phone: (_____) _____ - _____ **ext** _____ **Cell Phone:** (_____) _____ - _____ **ext** _____

Work Phone: (_____) _____ - _____ **ext** _____ **Fax #:** (_____) _____ - _____ **ext** _____

Employment Information

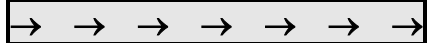
Business Name: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Employer's Email Address: _____
Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?): _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? ____/____/____

Has it ever occurred before? Yes No. When? _____

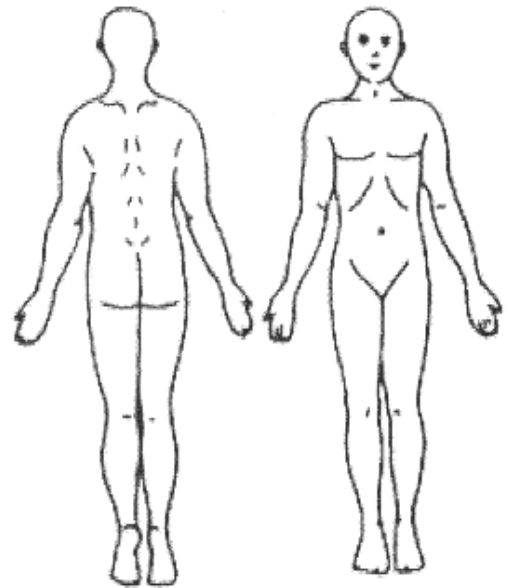
Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?



REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- chills fatigue night sweats weight loss
- daytime drowsiness fever weight gain

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- blindness change in vision field cuts photophobia
- blurred vision double vision glaucoma tearing
- cataracts eye pain itching wear glasses/contacts

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> bleeding | <input type="checkbox"/> ear drainage | <input type="checkbox"/> hearing loss | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> dentures | <input type="checkbox"/> ear pain | <input type="checkbox"/> history of head injury | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> tinnitus
(ringing in ears) |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> rhinorrhea
(runny nose) | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections | |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> headaches | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> snoring | |

Respiration: I DENY having any of the symptoms or problems listed below.

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- | | | |
|--|---|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> shortness of breath with exertion or exercise |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> swelling of legs |
| <input type="checkbox"/> claudication (leg pain/ache) | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> paroxysmal nocturnal dyspnea
(waking at night w/ shortness of breath) | |

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool caliber | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> birth control | <input type="checkbox"/> cramps | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> vaginal bleeding |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> burning urination | <input type="checkbox"/> hormone therapy | <input type="checkbox"/> urine retention | |

Male: I DENY having any of the symptoms or problems listed below.

- | | | |
|---|---|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention |

Endocrine: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

Skin: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> hair growth | <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> rash | |

Nervous System: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> limb weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremor |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures | <input type="checkbox"/> stress | <input type="checkbox"/> unsteadiness of gait/
loss of balance |
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of memory | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |

Psychologic: I DENY having any of the symptoms or problems listed below.

- | | | | |
|------------------------------------|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
|------------------------------------|--|--------------------------------------|--------------------------------------|

- anxiety bi-polar disorder depression mood change
 loss or change in appetite confusion insomnia

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphalaxis itching chronic nasal congestion sneezing
 food intolerance acute nasal congestion rash

Hematologic: I DENY having any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
 bleeding blood transfusion fatigue

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

Previous Care for this Same Condition: I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

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

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

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

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?

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	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

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

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

- ADD
- cystic kidney disease
- hypertension
- psychiatric problems
- alzheimers
- depression
- influenzal 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 sugery
- joint replacement
- spinal fusion
- cardiac catheterization
- gall bladder
- knee repair
- tonsilectomy
- carpal tunnel repair
- hemorrhoidectomy
- laminectomy
- other:
- coronary artery bypass
- hernia repair
- mastectomy

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

Menstrual History.

I... <input type="checkbox"/> currently have menses.	<input type="checkbox"/> currently DO NOT have menses.
My menses... <input type="checkbox"/> are regular.	<input type="checkbox"/> are NOT regular.
_____ Age of first menses	_____ Age when metaphase began
Date of last menses: ____/____/____	

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury
- head injury (loss of consciousness)
- motor vehicle accident
- broken bones
- head injury (no loss of consciousness)
- soft tissue injury (mild)
- disability (ies)
- industrial accident
- soft tissue injury (moderate)
- fall (severe)
- joint injury
- soft tissue injury (severe)
- fracture
- laceration (severe)
- other:

Immunizations: Please list the date(s) next to the immunization, if known.

- adenovirus
- hepatitis C
- pertussis
- tuberculosis
- anthrax
- influenza
- pneumococcal
- tularemia

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> botulism | <input type="checkbox"/> IPV (polio) | <input type="checkbox"/> pneumovax | <input type="checkbox"/> typhoid |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> PPD (mantoux test- TB) | <input type="checkbox"/> varivax (chicken pox) |
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> lyme disease | <input type="checkbox"/> rabies | <input type="checkbox"/> whooping cough (pertussis) |
| <input type="checkbox"/> flu | <input type="checkbox"/> measles | <input type="checkbox"/> rotavirus | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> haemophilus B | <input type="checkbox"/> meningococcal | <input type="checkbox"/> rubella | <input type="checkbox"/> other: |
| <input type="checkbox"/> hepatitis A | <input type="checkbox"/> MMR | <input type="checkbox"/> smallpox | |
| <input type="checkbox"/> hepatitis B | <input type="checkbox"/> mumps | <input type="checkbox"/> tetanus | |

Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> dairy | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> other: | | | |

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

- | | | | |
|----------------|-------------------|---------------|-------------------------|
| 1. angioedema | 3. GI disturbance | 5. joint pain | 7. shortness of breath |
| 2. anaphylaxis | 4. headache | 6. rash | 8. unspecified reaction |

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

- | | | | | | |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Social History: Mark all that apply below.

Alcohol: do not drink alcohol social consumption only drink the following regularly (mark below)
 beer liquor wine; quantity of _____ oz./glasses per day week month

My Dietary Intake consists mainly of the following: (mark all that apply)

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> high fat | <input type="checkbox"/> high salt | <input type="checkbox"/> low fiber |
| <input type="checkbox"/> high fiber | <input type="checkbox"/> low calorie | <input type="checkbox"/> low salt |
| <input type="checkbox"/> high protein | <input type="checkbox"/> low carbohydrate | <input type="checkbox"/> low sugar |

Mark the highest level of Education completed:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> pre-school | <input type="checkbox"/> high school | <input type="checkbox"/> college | <input type="checkbox"/> doctorate |
| <input type="checkbox"/> elementary school | <input type="checkbox"/> high school graduate | <input type="checkbox"/> college graduate | <input type="checkbox"/> graduate school |
| <input type="checkbox"/> middle school | <input type="checkbox"/> GED | <input type="checkbox"/> associates degree | <input type="checkbox"/> graduate degree |
| <input type="checkbox"/> vocational school | <input type="checkbox"/> high school – incomplete | <input type="checkbox"/> bachelors degree | <input type="checkbox"/> other: _____ |

Substance: never used illegal drugs has not used illegal drugs since _____ .
 never used IV drugs used illegal drugs for _____ (how long?)

Tobacco: Do not use tobacco Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
 Smoke: # ___ per Day Week Month; Chew: # _____ cans per Day Week Year

Insurance Information:

Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es)) Myself **ONLY**
 Spouse Worker's Comp Auto Insurance Medicare Medicaid Other (be specific): _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Policy Holder's Name: _____ Group #: _____
Policy Holder's Social Security #: _____ - _____ - _____ Primary Care Physician: _____

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ___/___/___ Time: _____ am/pm
Carrier: _____ Policy # _____
Carriers Phone #: (_____) _____ - _____ Adjuster: _____
Claim #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____ Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

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

Patient Print Name: _____ Date: _____
Patient's Signature: _____ Date: _____

Dr. Jennifer Belesi and Dr. Jason Mavor feel that it is very important that we coordinate with your doctor(s) and keep them up to date on your treatment and progress here at our office. Please fill in **any** and **all** information.

Primary Care Physician: _____ Phone#: _____

Address: _____

Dentist : _____ Phone#: _____

Address: _____

OB/GYN: _____ Phone#: _____

Address: _____

Massage Therapist / Acupuncturist: _____ Phone#: _____

Address: _____

Podiatrist / Other: _____ Phone#: _____

Address: _____

I give authorization to Cedar Chiropractic Wellness Center in Hopkinton to release my health care information to the above doctors.

Patient's name: _____

Patient's signature: _____

Date: ____/____/____