

Confidential Patient Health Record Cedar Chiropractic, 77 West Main St.,Hopk.,MA

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

Last: _____ First: _____ Middle: _____
Birth Date: ___/___/___ Age: ___ Sex: M / F SSN: _____ Marital Status: S M W D
Height _____ Weight _____ R L Handed Glasses Contact Lenses
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ - _____ ext _____ Work Phone: (_____) _____ - _____ ext _____
Cell Phone: (_____) _____ - _____ ext _____ Email Address: _____
Spouses Name: _____ Children (Names and Ages): _____

Emergency Contact

Last: _____ First: _____ Relationship: Spouse Relative Friend
Other _____ PRIMARY CARE PHYSICIAN: _____
Home Phone: (_____) _____ - _____ ext _____ Cell Phone: (_____) _____ - _____ ext _____
Work Phone: (_____) _____ - _____ ext _____

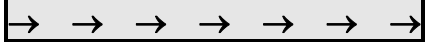
Employment Information

Business Name: _____
Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____
Occupation/Job Title/Description: _____

Current Health Condition

Unwanted Condition (Why are you here today?) _____

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

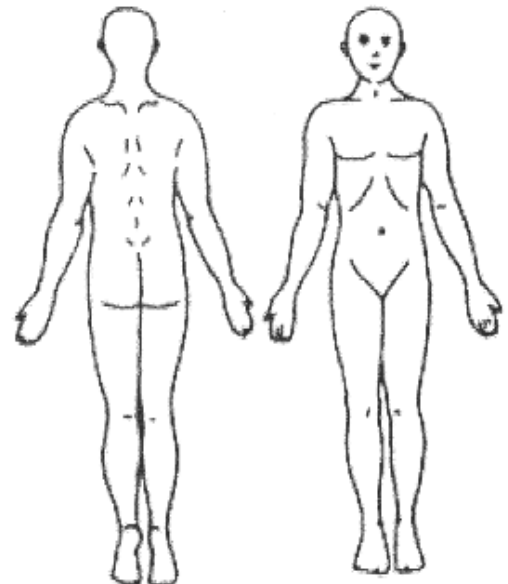
Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

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

Condition/Pain STARTED on what Date: _____

Do you have any other health concerns? _____



Patient Name: _____

Date: _____

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.

- | | | | |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> fever | <input type="checkbox"/> weight gain | |

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

- | | | | |
|---|---|-----------------------------------|--|
| <input type="checkbox"/> spots | <input type="checkbox"/> change in vision | <input type="checkbox"/> trauma | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> 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"/> TMJ problems |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> rhinorrhea (runny nose) | <input type="checkbox"/> tinnitus (ringing in ears) |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throat | <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"/> low blood pressure |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> heart problems | <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"/> shortness of breath with exertion or exercise | <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"/> 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 | <input type="checkbox"/> urine retention |

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

- | | | | |
|--|---|------------------------------------|--|
| <input type="checkbox"/> cold/heat intolerance | <input type="checkbox"/> excessive hunger or thirst | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> frequent urination | <input type="checkbox"/> hair loss | <input type="checkbox"/> loss/change in appetite |

Patient Name: _____

Date: _____

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

- changes in nail texture hair loss itching skin lesions / ulcers
- changes in skin color hives tingling varicosities
- hair growth history of skin disorders rash

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

- dizziness limb weakness numbness slurred speech tremor
- facial weakness loss of consciousness seizure/convulsions stress unsteadiness of gait
- headache loss of memory sleep disturbance strokes loss of balance

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

- anxiety behavioral change depression memory loss
- confusion bi-polar disorder insomnia mood change

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

- anaphylaxis 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

Previous Care for Same Condition: I have not 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: _____ Was the treatment beneficial in resolving condition? 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: _____

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.

- AD/HD
- eczema
- allergies
- anemia
- asthma
- bedwetting
- other:
- chicken pox
- Crohn's
- depression
- diabetes
- ear infections
- fetal drug exposure
- headaches
- hepatitis
- HIV
- measles
- mumps
- psoriasis
- scoliosis
- seizure disorder
- sickle cell anemia
- spina bifida
- Lyme Disease
- cerebral palsy

Patient Name: _____

Date: _____

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

- AD/HD kidney disease hypertension vertigo
- Alzheimer's neurological condition pneumonia scoliosis
- anemia diabetes liver disease seizures
- arthritis heart disease lung disease shingles/chicken pox
- asthma eczema fibromyalgia Rheumatoid /Inflammatory Arthritis
- cancer emphysema lupus erythema Gout
- Crohn's/colitis CVA (stroke) multiple sclerosis thyroid problems
- Lyme Disease Collagen/Vascular Parkinson's disease pneumonia

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

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 gall bladder knee repair tonsillectomy
- carpal tunnel repair hemorrhoidectomy laminectomy other:
- cardiac bypass hernia repair mastectomy

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

- back injury head injury motor vehicle accident
- fracture concussion fall (severe)
- disability industrial accident joint injury

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

- Alcohol: Never Social Consumption only Frequent
- Diet (please mark all that apply): High Fat High Fiber High Protein High Salt High Sugar
- Low Calorie Low Carb Low Fiber Low Salt Low Sugar
- Education: (please mark the highest level completed): High School Assoc/Technical College Graduate Doctorate
- Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____
- Tobacco: Deny Tobacco Use Live with a smoker Quit smoking Chew
- Smoke; # _____ per Day Week Month

Insurance Information:

- Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es)) Myself ONLY
- Spouse Worker's Comp Auto Insurance Medicare Medicaid Private Self-pay
- Personal Health Insurance Carrier: _____ Health ID Card #: _____
- Policy Holder's Name: _____ Group #: _____
- Policy Holder's Date of Birth: _____ - _____ - _____

Patient Name: _____

Date: _____

Dr. Jennifer Belesi and Dr. Jason Mavor feel that it is very important 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 Signature _____