

Patient Health Record

Welcome to Millner Family Chiropractic!

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific and individualized chiropractic care.

GOALS FOR MY CARE

Which best describes your reason for consulting our office?

I have a specific concern and require help only with this concern.

I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

I want to be healthier 5 years from now than I am today.

Please tell us the name of the last doctor who put you on a health development program:

_____ Were you able to stay with the program? Yes No

If so, how long? ___ months ___ years. What were your results? _____

_____ Were the results permanent? Yes No

MEDICATIONS I NOW TAKE

Stomach Medications	Stimulants
Pain Killers (including aspirin)	Blood Thinners
Muscle Relaxers	Anxiety/depression
Blood Pressure	Hormone Therapy
Insulin	Cholesterol

HEALTH HABITS

	Yes	No	
Do you smoke?			___ packs/day
Do you drink alcohol?			___ drinks/month
Do you drink coffee/soda?			___/day
Do you exercise regularly?	No	Moderate	Daily
Do you wear	Heel Lifts	Arch Supports	

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Severe or frequent headaches	Low energy	Shingles	For Women:	
Sinus problems	Heart surgery/ pacemaker	Kidney problems		Are you pregnant? Yes No
Dizziness	Heart murmur	Hepatitis		Are you nursing? Yes No
Loss of sleep	High/low blood pressure	Cancer	Are you taking birth control? Yes No	
Pain between the shoulders	Difficulty breathing	Chemotherapy	Do you experience painful periods? Yes No	
Frequent neck pain	Asthma	Anemia	Do you have irregular cycles? Yes No	
Numbness or pain in arms/legs/hands	Arthritis	Anxiety/Depression		
Lower back problems	Alcohol/drug abuse	Thyroid problems		
Digestive problems	Lowered immune system	Heart attack		
Ulcers/colitis	Diabetes	Carpal Tunnel		
	Irregular Bowel	Other		

Are you healthier now than you were 5 years ago? Yes No If yes, what did you do to accomplish this?

If no, why do you think your health has deteriorated over the last 5 years? _____

Will you be healthier 5 years from now than you are today? Yes No

Why or why not? _____

What would you like your health to be 5 years from now? _____

How many Medical Doctor's office visits did you and your family have last year?

None Less than 5 More than 5 More than 10 More than 20 Too many

THE POWER OF THE BODY

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of **vertebral subluxations**. Stress that may be physical, chemical or emotional may cause these **subluxations**. The practice of chiropractic is based on the location and reduction of nerve system interference caused by the **vertebral subluxations**.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following.

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR BIRTH:

	No	Yes	Explain:
1) Drugs/medicine/tobacco/alcohol in pregnancy?			_____
2) Labor chemically induced?			_____
3) Forceps/Vacuum Extraction/C-section?			_____
4) Premature delivery?			_____
5) Vaccinations?			_____
6) Falls in first year of life?			_____
7) Any health related problems?			_____

PLEASE TELL US ABOUT ANY STRESS RELATED TO YOUR CHILDHOOD:

	No	Yes	Explain:
1) Any falls or injuries?			_____
2) Allergy/Asthma or Respiratory problems?			_____
3) Ear Infections?			_____
4) Digestive Problems?			_____
5) Hyperactivity?			_____
6) Any other health related problems?			_____

PLEASE TELL US ABOUT ANY STRESS UP TO THE PRESENT:

	No	Yes	Explain:
1) Auto Injuries?			_____
2) Work Injuries?			_____
3) Sports Injuries?			_____
4) Work Stress?			_____
5) Family/Home Stress?			_____
6) Prescription Drug Use?			_____
7) Ever Hospitalized/Surgeries?			_____
8) Recurring Illnesses?			_____
9) Limited Exercise?			_____
10) Poor Nutrition?			_____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor(s) to work with my condition through the use of adjustments, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Patient or Guardian Signature: _____ Date: _____