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.

ABOUT THE PATIENT

Name___________________________________

Address_________________________________

City____________________State_____Zip_____

Age____ Birthdate __/__/__ Gender M F

Home Phone ___________ Work #__________

SS#_______-_______-______

Employer______________________________

Type of work ___________________________

Marital Status Mar. Sing. Div. Wid.

Family M.D. or clinic ____________________

How many children do you have? ___________

Names__________________ Age __________

___________________ __________

___________________ __________

E-mail address ___________________________

Would you like us to email you our free weekly health tip? ? Yes ? No

REASON FOR THIS VISIT

Describe the purpose of this visit __________

____

Is the purpose of this appointment related to

Job Auto Fall Sports Daily Life

Chronic Discomfort Home Injury Other

Please explain _________________________

When did this health challenge begin?______

Does this interfere with Work Sleep

Daily Routine Other Activities

Explain ______________________________

What are **your** objectives in consulting us?

____

What are your health **goals** once these objectives have been met? _______________

____

What other wellness professionals are currently a part of your health care team?

massage therapist acupuncturist

naturopath homeopath Other _______

Have you seen other professionals for this?

Yes No

Dr.'s Name (s) ______________________

Type of Treatment ____________________

Results ______________________________

ABOUT THE SPOUSE OR PARENTS

Name(s) ______________________________

Employer _____________________________

Type of Work __________________________

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office?_________________________

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits?__________________________________

Previous Chiropractor's Name ___________________________

Approximate Date of Last Visit __________________________

Has any *adult* in your family seen a Chiropractor? Yes No

Has any *child* in your family seen a Chiropractor? Yes No

Were you aware that

- …Doctors of Chiropractic work with the nervous system? . Yes No
- …the nervous system controls all bodily functions and systems? Yes No
- …Chiropractic is the largest natural healing profession in the world? Yes No
- …if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

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
	Anxiety/depression
Muscle Relaxers	Hormone Therapy
Blood Pressure	Cholesterol
Insulin	_____________

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
Sinus problems	Heart surgery/ pacemaker	Kidney problems
Dizziness	Heart murmur	Hepatitis
Loss of sleep	High/low blood pressure	Cancer
Pain between the shoulders	Difficulty breathing	Chemotherapy
Frequent neck pain	Asthma	Anemia
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
		_______________
		_______________

For Women:
Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking birth control? Yes No
Do you experience painful periods? Yes No
Do you have irregular cycles? Yes No

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. 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: ____________