Equilibrium Health + Wellness

Today's Date: _____/_____/_____

Confidential Patient Health Record

How did you hear about us? ☐ Family ☐ Friend ☐ Doctor Referral ☐ Internet ☐ Walked By ☐ Insurance Plan

PERSONAL INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____

Gender: ☐ Male ☐ Female

Birth Date: _____ / _____ / _____ Social Security Number: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

PRIMARY PHONE to receive a call or message from the doctor: (_____) _____-_____

Other phone numbers: Cell: (_____) _____-_____ Home: (_____) _____-_____

Email Address: _____

EMERGENCY CONTACT

First Name:_____ Last Name:_____

Relationship: ☐ Spouse ☐ Family Member ☐ Friend ☐ Other _____

Contact number of this person: (_____) _____-_____

MAIN COMPLAINT

_____

_____

BASIC HISTORY OF THIS CONDITION

When did this condition BEGIN? _____ Has this happened before? ☐ YES ☐ NO

If YES: How many times? _____ When was the last episode? _____

Describe progression of problem since it started:

☐ started to get better, but leveled off ☐ constantly getting worse ☐ constant since starting

☐ got better initially, but now is worse than at the beginning

How did it start?

☐ Auto Related ☐ Job Related ☐ Lifting ☐ Slip/Fall ☐ Sports Activity

☐ During Exercise ☐ Slept Wrong ☐ Just Gradually Started ☐ Unknown

☐ Other: _____

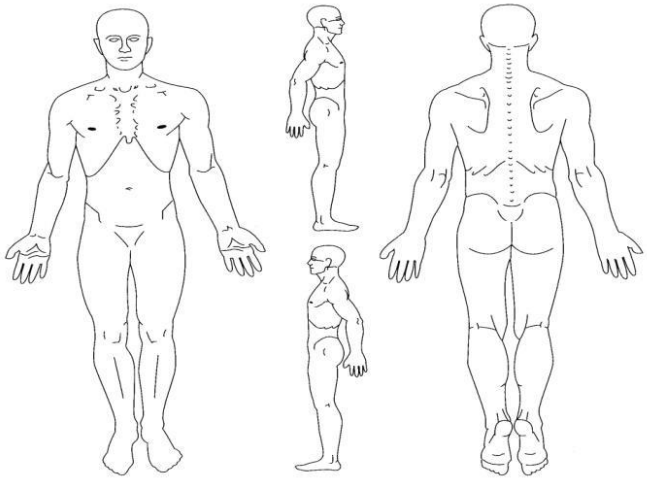
If because of an accident, date of accident: _____

Did condition/pain start due to the accident? ☐ Yes ☐ No

If no, when did the condition/pain start? _____

PLEASE LABEL ON THE DIAGRAM THE AREA FOR THIS CONDITION
Indicate the location and type of your sensations right now.

A=Ache B=Burning N=Numbness P=Pins/Needles S=Stabbing

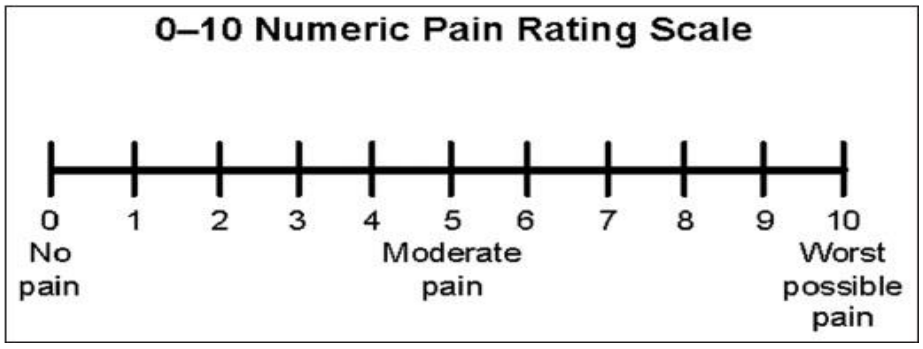


Please tell us if you have ANY OTHER CONDITION or SYMPTOM that you are SUFFERING from, in addition to that which you are now consulting us for.

_____

_____

Place an X on the line below to show the amount of pain you are currently feeling.



REVIEW OF SYSTEMS

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

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

Eyes/Vision: ☐ **I DENY having or have had 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 or have had any of the symptoms or problems listed below**

☐ bleeding ☐ ear drainage ☐ hearing loss ☐ nosebleeds ☐ sore throat
☐ dentures ☐ ear pain ☐ history of head injury ☐ postnasal drip ☐ tinnitus
☐ fainting ☐ difficulty swallowing ☐ hoarseness ☐ snoring ☐ TMJ problems
☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections ☐ dizziness
☐ headaches ☐ nasal congestion ☐ rhinorrhea (runny nose)

Respiration: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ asthma ☐ coughing up blood ☐ sputum production
☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ **I DENY having or have had any of the symptoms or problems listed below**

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

Gastrointestinal: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ abdominal pain ☐ diarrhea ☐ indigestion ☐ vomiting with or without blood
☐ belching ☐ difficulty swallowing ☐ jaundice ☐ abnormal stool color
☐ black - tarry stools ☐ heartburn ☐ nausea ☐ abnormal stool consistency
☐ constipation ☐ hemorrhoids ☐ rectal bleeding ☐ abnormal stool caliber

Female: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ birth control ☐ cramps ☐ urine retention ☐ irregular menstruation
☐ breast lumps/pain ☐ frequent urination ☐ vaginal bleeding ☐ pregnancy
☐ burning urination ☐ hormone therapy ☐ vaginal discharge

Male: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ burning urination ☐ frequent urination ☐ prostate problems
☐ erectile dysfunction ☐ urine retention ☐ hesitancy and/or dribbling

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Endocrine: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ cold intolerance ☐ excessive hunger ☐ goiter ☐ unusual hair growth
☐ diabetes ☐ excessive thirst ☐ hair loss ☐ voice changes
☐ excessive appetite ☐ heat intolerance ☐ abnormal frequency of urination

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Skin: ☐ **I DENY having or have had any of the symptoms or problems listed below**

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

Nervous System: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ dizziness ☐ limb weakness ☐ numbness ☐ loss of consciousness
☐ facial weakness ☐ seizures ☐ strokes ☐ sleep disturbance
☐ stress ☐ loss of memory ☐ slurred speech ☐ unsteadiness of walking
☐ headache ☐ tremor ☐ loss of balance ☐ tics

Psychological: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ behavioral change ☐ convulsions ☐ memory loss ☐ anxiety ☐ bipolar disorder
☐ depression ☐ mood change ☐ loss or change in appetite ☐ confusion ☐ insomnia

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Allergy: ☐ **I DENY having or have had any of the symptoms or problems listed below**

☐ anaphylaxis ☐ itching ☐ sneezing ☐ chronic nasal congestion
☐ food intolerance ☐ acute nasal congestion ☐ rash ☐ medication allergy

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Hematologic: ☐ **I DENY having or have had any of the symptoms or problems listed below**

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

SOCIAL HISTORY

Alcohol: ☐ Never ☐ Social consumption only: ☐ Beer ☐ Liquor ☐ Wine How many glasses per week?_____

Drugs: ☐ Deny any drug use ☐ Have not used drugs since _____

Tobacco: ☐ Deny tobacco use ☐ No longer smoke

☐ Smoke: # _____ per ☐ Day ☐ Week ☐ Month ☐ Live with a smoker

☐ Chew: #_____ cans per ☐ Day ☐ Week ☐ Month

PAST HEALTH HISTORY

Previous care FOR SAME CONDITION: ☐ **I DENY having seen a doctor for this condition**

Who did you see? ☐ DC ☐ MD ☐ DO ☐ Acupuncturist ☐ OTHER_____

Practitioner's name? _____ _____

What type of treatment? (Circle one) Chiropractic Medical Acupuncture

Did the treatment resolve the condition? ☐ Yes ☐ No - Explain:_____

Date of Last Chiropractic Session: _____

Date of Last Medical Session: _____

Date of Last Acupuncture Session: _____

CURRENT MEDICATION(s): List medications you are **currently** taking

Medications	Dosage	For what condition?	How long have you been taking this?

CURRENT VITAMINS: List vitamins you are **currently** taking

Vitamins	Why are you taking this?	How long have you been taking this?

List any surgeries: _____

_____

Patient Signature: _____ Date: _____