



Buchanan Chiropractic Clinic, P.C.
 5124 N Henry Blvd
 Stockbridge, GA 30281
 Voice: 770.474.6680 Fax: 770.474.3633

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.
 Last: _____ First: _____ Middle: _____
 Suffix: Jr Sr II III Sex: Male / Female Race: _____
 Birth Date: ____/____/____ Age: _____ Social Security #: _____-_____-_____
 Driver's License #: _____ State: _____
 Marital Status: Single Married Widowed Divorced Separated
 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

Last: _____ First: _____ Middle: _____
 Relationship: Spouse Relative Friend Parent Other _____
 Home Phone: (_____) _____ - _____ ext _____ Cell Phone: (_____) _____ - _____ ext _____
 Work Phone: (_____) _____ - _____ ext _____
 Primary Care Physician: _____ Number: _____

I _____ authorize Buchanan Chiropractic Clinic to provide my primary care physician with my reports and/or treatment notes.

Patient Signature: _____

Patient Name: _____

Date: _____

Employment Information

Business Name: _____

Phone: (____) _____ - _____ **Fax #:** (____) _____ - _____

Employer's Email Address: _____

Occupation/Job Title: _____

Work: _____ hrs / day or week

Description of work:

Job Classification: Sedentary(<5lbs) Light(5-20lbs) Moderate(20-50lbs) Heavy(>50 lbs)

Lifting Frequency: Constant (67-100%/day) Frequent (33-66%/day) Occasional (0-32%/day)

Lifting Postures: with Arms High Near from Knee Off Posture from Torso

Work Activity Postures: (hrs/day)

bending: _____ h/d climbing: _____ h/d kneeling: _____ h/d pulling: _____ h/d pushing: _____ h/d

reaching: _____ h/d sitting: _____ h/d standing: _____ h/d twisting: _____ h/d walking: _____ h/d

Repetitive Activities: (hrs/day)

assembly/fine manipulation: _____ h/d computer use/typing: _____ h/d grasping: _____ h/d

hand tool use: _____ h/d operation of machinery controls: _____ h/d phone use: _____ h/d

Condition's Effect On Job Performance:

No Effect Mild Painful (Can do) Mod Painful (limited ability)

Mod/ Limited Duty Severe/ Limited Duty Severe (can't perform duties)

Patient Name: _____

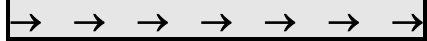
Date: _____

Current Health Condition

Unwanted Condition (What brings you 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? _____

Mechanism of on set:

Auto: Driver/Passenger Pedestrian (refer to auto accident form)

Work related: Fall Falling Object Lifting Overexertion

Repetitive Motion Other: _____

Other Liability: Slip or Fall Other: _____

Other No Liability: Etiology unknown Overexertion Repetitive Use

Slept Wrong Slip or Fall No Injury

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

Condition/Pain STARTED on what Date: _____

What is the quality of your pain? Burning Dull/Aching Localized

Radiating Sharp Shooting Stabbing Throbbing Tightness Tingling Other: _____

Pain timing: Worse: Morning Afternoon with Activity Constant Intermittent

Pain better with: Warm Temp Cold Temp Other: _____

Worse with: Warm Temp Cold Temp Other: _____

Headaches: Location: Occipital Frontal Left Temporal Right Temporal Parietal Sinus

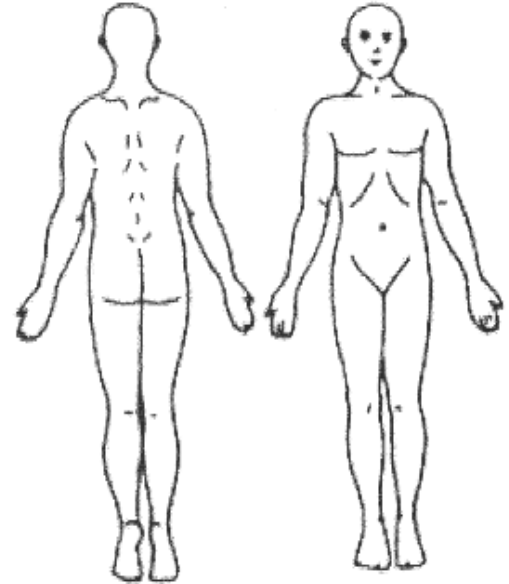
Quality: Dull Sharp Throbbing Stabbing Aura No Aura Doctor's Notes: _____

Types: Hat Band Cluster Migraine Tension

Radiation: Left / Right / Bilateral

Weakness: Left / Right / Bilateral

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



On a scale of zero to ten, I rate my discomfort as follows: (10=worst)

Active: 0 1 2 3 4 5 6 7 8 9 10

Resting: 0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____

Date: _____

Daily Activities: Effects of Current Condition on Performance

- Bending: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Care –Infirm Family: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Carrying Groceries: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Change Posn–Sit–Stand: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Climb Stairs: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Driving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Extended Computer Use: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Feeding: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Household Chores: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Kneeling: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lift Children: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lifting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Pet Care: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Reading (Concentration): **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Bathing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Dressing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Self Care–Shaving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sexual Activities: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Sleep: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Static Standing: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Walking: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Yard Work: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

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. Please check only those conditions present

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

Eyes/Vision: **I DENY** having any of the symptoms or problems listed below. Please check only those conditions present

- 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. Please check only those conditions present

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

Patient Name: _____

Date: _____

Respiration: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

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

Cardiovascular: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

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

Gastrointestinal: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

- abdominal pain diarrhea indigestion abnormal stool caliber vomiting blood
 belching difficulty swallowing jaundice abnormal stool color
 black - tarry stools heartburn nausea abnormal stool consistency
 constipation hemorrhoids rectal bleeding vomiting

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

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

Male: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

- burning urination frequent urination prostate problems
 erectile dysfunction hesitancy/ dribbling urine retention

Endocrine: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

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

Skin: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

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

Nervous System: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

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

Psychologic: I DENY having any of the symptoms or problems listed below. Please check only those conditions present

- anhedonia behavioral change convulsions 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. Please check only those conditions present

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

Patient Name: _____

Date: _____

Hematologic: **I DENY** having any of the symptoms or problems listed below. Please check only those conditions present

- 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: _____ 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: _____

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?

Childhood Illness (es): Check 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

Adult Illness(es): Check 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 (discoïd) past history of similar symptoms
- cancer emphysema lupus erythema (systemic) STD's (unspecified)

Patient Name: _____

Date: _____

- 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

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 catheterization gall bladder knee repair tonsillectomy
- 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:

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

- general family alive deceased normally developed no significant disease has/had: _____
- father alive deceased normally developed no significant disease has/had: _____
- mother alive deceased normally developed no significant disease has/had: _____
- paternal grandfather alive deceased normally developed no significant disease has/had: _____
- paternal grandmother alive deceased normally developed no significant disease has/had: _____
- maternal grandfather alive deceased normally developed no significant disease has/had: _____
- maternal grandmother alive deceased normally developed no significant disease has/had: _____
- son (s) alive deceased normally developed no significant disease has/had: _____
- daughter(s) alive deceased normally developed no significant disease has/had: _____
- brother(s) alive deceased normally developed no significant disease has/had: _____
- sister(s) alive deceased normally developed no significant disease has/had: _____

Patient Name: _____

Date: _____

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

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

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

- high fat high salt low fiber
- high fiber low calorie low salt
- high protein low carbohydrate low sugar

What hobbies do you have?

Insurance Information:

Who Is Responsible For Your Bill? **YOU and...** (mark appropriate box(es)) Myself **ONLY**

Spouse Worker's Comp Auto Insurance Medicare Other (be specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____ - _____ - _____

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

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____