



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

*****If you are retired please just write retired on the first line of this section.*****

Business Name: _____

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

Employer's Email Address: _____

Occupation/Job Title: _____

Work: _____ hrs / day or week

Description of work:

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

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)**

Daily Activities: Effects of Current Condition on Performance

- Exercise: **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
- Sitting: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- 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
- Driving: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Bending: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Lift/Push/Pull: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform
- Recreational Activities: **No Effect** **Mild** Painful (Can do) **Mod** Painful (Limited) **Sev** Unable to Perform

*****If you have no activity limitation your insurance company may view the treatment as maintenance care and the services may not be covered.*****

Patient Name: _____

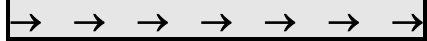
Date: _____

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? _____

How did your condition begin?:

Auto Work Related Fall Overexertion Repetitive Motion
Slept Wrong Slip or Fall No Injury Etiology unknown

What is the quality of your pain? Burning Dull/Aching Localized
Radiating Sharp Shooting Stabbing Throbbing Tightness

Pain timing: Worse: Morning Afternoon with Activity Constant

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

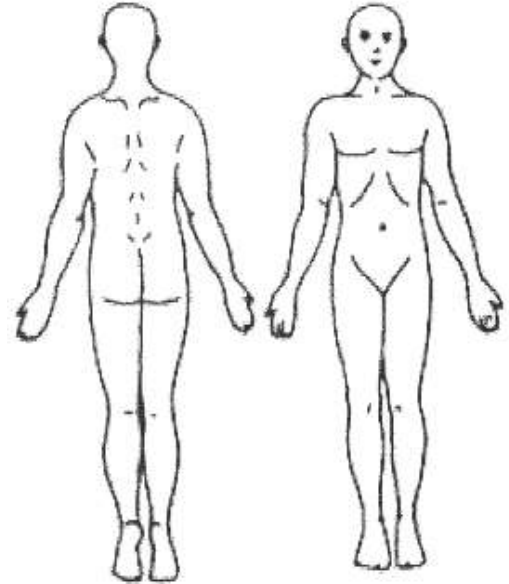
Quality: Dull Sharp Throbbing Stabbing Aura No Aura Doctor's Notes: _____

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: _____

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.

*****If you do not have any of the symptoms listed please check I DENY in each category.*****

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

- | | | | |
|---|----------------------------------|---------------------------------------|--------------------------------------|
| <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. Please check only those conditions present

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <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. Please check only those conditions present

- | | | | | |
|-------------------------------------|--|---|---|--|
| <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"/> tinnitus
(ringing in ears) |
| <input type="checkbox"/> swallowing | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> rhinorrhea
(runny nose) | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throats | <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. Please check only those conditions present

- | | | |
|---------------------------------|--|--|
| <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. Please check only those conditions present

- | | | |
|--|---|---|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> shortness of breath
with exertion or exercise |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <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"/> heart problems | <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. Please check only those conditions present

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool
caliber | <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. Please check only those conditions present

- | | | |
|---|---|--|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention |

Patient Name: _____

Date: _____

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

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.

Patient Name: _____

Date: _____

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.

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hayfever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> 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.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental surgery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | |

Patient Name: _____

Date: _____

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
- broken bones
- disability (ies)
- fall (severe)
- fracture
- head injury (loss of consciousness)
- head injury (no loss of consciousness)
- industrial accident
- joint injury
- laceration (severe)
- motor vehicle accident
- soft tissue injury (mild)
- soft tissue injury (moderate)
- soft tissue injury (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: _____

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

Patient Name: _____

Date: _____

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:** _____