

Confidential Patient Record

Name _____ Sex _____ Age _____ DOB _____ Date _____

Address _____ City _____ State _____ Zip _____

Home _____ Business _____ Fax _____ Mobile _____

Social Security _____ Email _____

Occupation _____ Employer _____

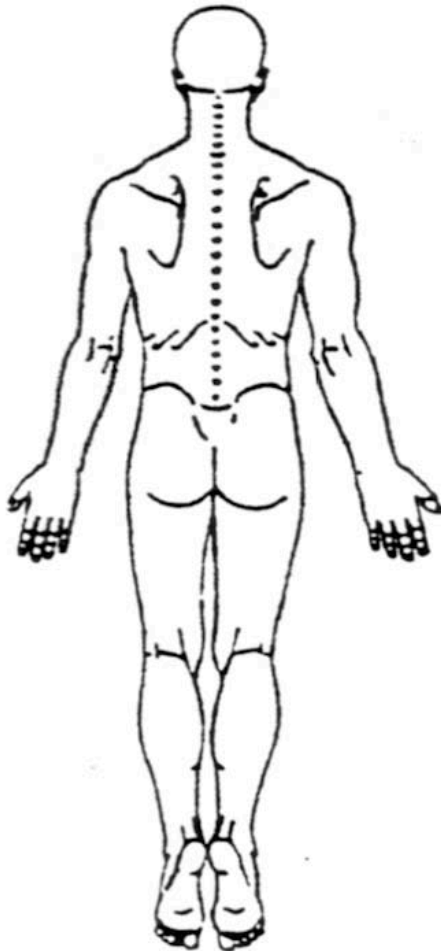
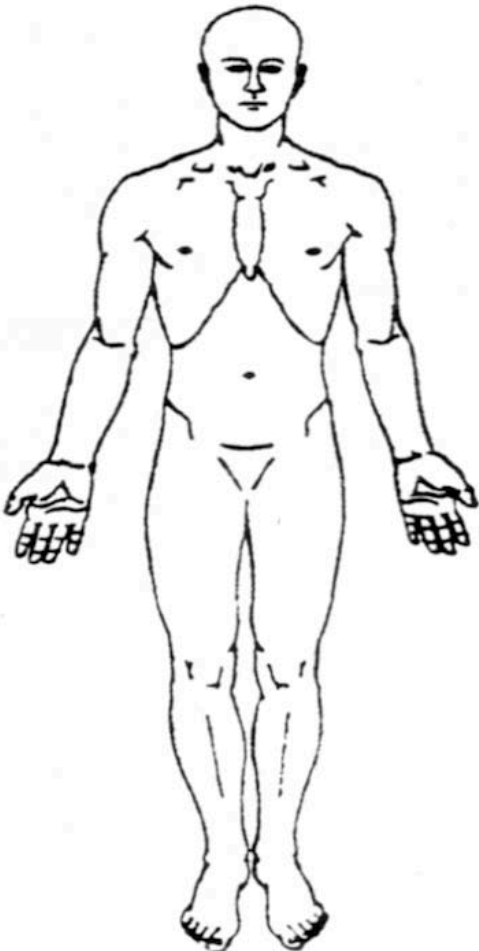
Names/Ages of Children _____ Marital Status (circle one) Married Single Divorced Widowed

Name of Spouse _____ Spouse's Employer _____

Name and Phone of Emergency Contact _____ Relationship _____

How did you hear about our office? _____

Have you ever been to a Chiropractor before? Y N If yes, which doctor? _____



Use the diagram to draw any **scars** (major & minor), **abnormal sensations** or **pain** (please indicate if it travels).

Rate your problem by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your problem by circling the one number that best describes your pain at its **LEAST** in the past 24 hours

1 2 3 4 5 6 7 8 9 10

Rate your problem by circling the one number that best describes your pain on **AVERAGE** for the past week.

1 2 3 4 5 6 7 8 9 10

NOTE: Please feel free to use the back page of this form if you need more room

Complaints | Please list your health concerns and rate their severity (1-10). This can include current injuries or chronic complaints (ex. "bad hip/knee/shoulder"), overweight, etc.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Goals | What are your goals for seeing Dr. Ian Hollaman or Dr. Karen Hollaman?

Limitations | What limitations do you have, if any? (ex. Unwilling to take supplements, working in excess of 50 hours a week, won't give up smoking or alcohol, etc).

Stress Level | Rate your stress level currently on a scale from 1 -10 (10 being the most stress). Note that stress can come in forms such as overwork, health concerns, family, work responsibilities, anxiety, insomnia, road rage, depression, relationships, etc.

Overall stress: _____ Main reason for stress: _____

If over a level 5, what steps are you currently taking to reduce your stress? _____

Energy Level | List on a scale from 1-10 (1 is lowest, 10 is highest) what is your energy level during the following times:

AM _____ Afternoon _____ Evening _____ Late PM _____ After meals _____ Overall _____

Sleep Quality | How is your sleep? (Check all that apply) Restful Restless Hard to get to sleep
 Hard to get to sleep Wake up often Wake up early Nightmares

What time do you usually go to sleep? _____ Hours of sleep/night? _____

Exercise | Do you exercise? _____ How often? _____ For how long per session? _____

Smoking | Do you currently smoke? _____ How much? _____ How often? _____

Daily Habits | For each of these items listed below specify if you consume them and how often (i.e. 2 cups/day).

Coffee/Tea: _____ Soda: _____ Alcohol: _____ Water: _____ Fast food: _____

Vitamins/Minerals: _____

Allergies | Please list any known allergies including environmental, food sensitivities, seasonal, drug, etc.

Medical History | Please describe any conditions which are under the care of a physician.

Diagnosis:

-

Date of onset _____ Duration of current symptoms _____

Doctor (s) involved, their specialty _____

How diagnosed (what tests)? _____

Current treatment (medication, etc.) _____

Treatment received in past, if any, and how it worked _____

Current medical/osteopathic doctor _____

Medications | Please list any medications you are taking or have taken and for how long. State the reason for taking it.

- | | | | | |
|--|---|---|---|-----------------------------------|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Muscle Relaxors | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Pain Killers | <input type="checkbox"/> Yeast/Fungai Medications | |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Cardiac/Heart Medication | <input type="checkbox"/> Hormones (DHEA, estrogen, progesterone, thyroid, etc.) | <input type="checkbox"/> Other | |

Surgeries/Hospitalizations | What surgeries, operations, traumas, car accidents etc. have you had?

- | | | | | |
|---------------------------------------|--|---------------------------------------|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Breast Implants | <input type="checkbox"/> C - Sections | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Laproscopy |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Biopsies | <input type="checkbox"/> D&C's | <input type="checkbox"/> Implants/Prosthesis | <input type="checkbox"/> Tonsils/Adenoid |

Other (please list all with brief details such as date, outcome, etc.)

Family History | Check those that apply and indicate the outcome and age of onset.

	Maternal		Paternal		Mother	Father	Sibling	Outcome
	Grandma	Grandpa	Grandma	Grandpa				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other:

Review of Systems | Please check the “NOW” box for all conditions that you are experiencing and mark the “PAST” box for any condition or symptoms experienced at any time in your life.

	Now / Past		Now / Past		Now / Past
General		Nose		G-I System	
Weight loss	<input type="checkbox"/> <input type="checkbox"/>	Nosebleeds	<input type="checkbox"/> <input type="checkbox"/>	Gas	<input type="checkbox"/> <input type="checkbox"/>
Weight gain	<input type="checkbox"/> <input type="checkbox"/>	Sinus Problems	<input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/>
Head		Lungs		Indigestion	<input type="checkbox"/> <input type="checkbox"/>
Headache	<input type="checkbox"/> <input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/> <input type="checkbox"/>	Ulcers	<input type="checkbox"/> <input type="checkbox"/>
Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Vomiting/Nausea	<input type="checkbox"/> <input type="checkbox"/>
Head trauma	<input type="checkbox"/> <input type="checkbox"/>	Pneumonia	<input type="checkbox"/> <input type="checkbox"/>	Abdominal pain	<input type="checkbox"/> <input type="checkbox"/>
Fainting	<input type="checkbox"/> <input type="checkbox"/>	Wheezing	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>
Blacking out	<input type="checkbox"/> <input type="checkbox"/>	Persistent Cough	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>
Eyes		Coughing/phlegm	<input type="checkbox"/> <input type="checkbox"/>	Blood in stool	<input type="checkbox"/> <input type="checkbox"/>
Change in vision	<input type="checkbox"/> <input type="checkbox"/>	Coughing blood	<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>
Cataracts	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	Gall bladder	<input type="checkbox"/> <input type="checkbox"/>
Light sensitivity	<input type="checkbox"/> <input type="checkbox"/>	Vascular		Liver disease	<input type="checkbox"/> <input type="checkbox"/>
Flashes in vision	<input type="checkbox"/> <input type="checkbox"/>	Chest pain	<input type="checkbox"/> <input type="checkbox"/>	G-U System	
Spots in vision	<input type="checkbox"/> <input type="checkbox"/>	Palpitations	<input type="checkbox"/> <input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/> <input type="checkbox"/>
Mouth		Ankle swelling	<input type="checkbox"/> <input type="checkbox"/>	Pain urinating	<input type="checkbox"/> <input type="checkbox"/>
Bleeding gums	<input type="checkbox"/> <input type="checkbox"/>	Cold feet/hands	<input type="checkbox"/> <input type="checkbox"/>	Blood in urine	<input type="checkbox"/> <input type="checkbox"/>
Cold sores	<input type="checkbox"/> <input type="checkbox"/>	Leg cramps	<input type="checkbox"/> <input type="checkbox"/>	Incontinence	<input type="checkbox"/> <input type="checkbox"/>
Dentures	<input type="checkbox"/> <input type="checkbox"/>	Calf pain	<input type="checkbox"/> <input type="checkbox"/>	Foul odor of urine	<input type="checkbox"/> <input type="checkbox"/>
Sore throat	<input type="checkbox"/> <input type="checkbox"/>	Varicose veins	<input type="checkbox"/> <input type="checkbox"/>	Increased urination	<input type="checkbox"/> <input type="checkbox"/>
Jaw pain	<input type="checkbox"/> <input type="checkbox"/>	Low blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Decreased urination	<input type="checkbox"/> <input type="checkbox"/>
Changes in taste	<input type="checkbox"/> <input type="checkbox"/>	High blood pressure	<input type="checkbox"/> <input type="checkbox"/>	Urinary infection	<input type="checkbox"/> <input type="checkbox"/>
Hoarseness	<input type="checkbox"/> <input type="checkbox"/>			Genital infection	<input type="checkbox"/> <input type="checkbox"/>
				Difficult urination	<input type="checkbox"/> <input type="checkbox"/>
				Dribbling	<input type="checkbox"/> <input type="checkbox"/>
Conditions				Menstrual Cycle	
Hypertension	<input type="checkbox"/> <input type="checkbox"/>	Gout	<input type="checkbox"/> <input type="checkbox"/>	32 days or more	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	24 days or less	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>	Osteoporosis	<input type="checkbox"/> <input type="checkbox"/>	Pain/Cramping	<input type="checkbox"/> <input type="checkbox"/>
Heart condition	<input type="checkbox"/> <input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/> <input type="checkbox"/>	Irritable/Depressed	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic arthritis	<input type="checkbox"/> <input type="checkbox"/>	High cholesterol	<input type="checkbox"/> <input type="checkbox"/>	Hot Flashes	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/>	Migraines	<input type="checkbox"/> <input type="checkbox"/>	Skin	
Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	TIA's	<input type="checkbox"/> <input type="checkbox"/>	Changes in moles	<input type="checkbox"/> <input type="checkbox"/>
Alcoholism	<input type="checkbox"/> <input type="checkbox"/>	Headache unlike	<input type="checkbox"/> <input type="checkbox"/>	Eczema	<input type="checkbox"/> <input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/> <input type="checkbox"/>	any previously		Rash	<input type="checkbox"/> <input type="checkbox"/>
Polio	<input type="checkbox"/> <input type="checkbox"/>	experienced		Dry skin	<input type="checkbox"/> <input type="checkbox"/>
Parkinson's	<input type="checkbox"/> <input type="checkbox"/>			Bruising	<input type="checkbox"/> <input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/>			Itching	<input type="checkbox"/> <input type="checkbox"/>
				Brittle nails	<input type="checkbox"/> <input type="checkbox"/>

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