NEW YORK CHIROPRACTIC ASSOCIATES

CONFIDENTIAL PATIENT HEALTH RECORD

Date _____

Name: _____
DOB: _____ Age _____
Sex: ○ Male ○ Female ○ Unspecified
Address: _____
City: _____ State: _____
Zip: _____
Marital Status: ○ Single ○ Married ○ Divorced ○ Widow
Social Security:
_____

Referred to this office by: _____
_____

Business Employer: _____
Occupation: _____

Chief Complaint: _____
When did this condition begin? _____
Is Condition: ○ Auto Related ○ Work Related
○ Other ○ No Injury
Has this ever occurred before? ○ Yes ○ No
Explain: _____
_____
_____
Date of Accident: _____
Complaint/Pain onset date: _____

Home Phone: _____
Cell Phone: _____
Cell Phone Carrier: _____
Email Address: _____

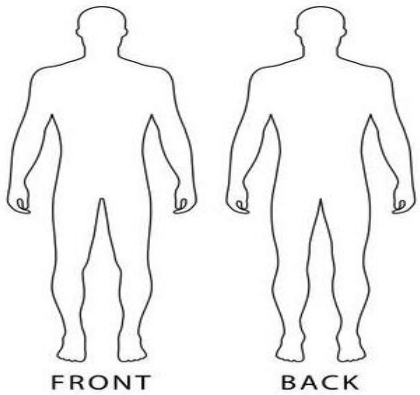
Emergency Contact Name and Number: _____
_____
Relationship: _____

Children: ○ Yes ○No
Name & Ages _____
_____
_____

Health Insurance Carrier: _____
Member Id # _____
Group # _____
Responsible for the bill: ○ Self ○ Spouse ○ Parent/Guardian
○ Other _____

Uses the letter below to indicate the type and location your sensation right now?

○ **A**=Ache ○ **B**=Burning ○ **N**=Numbness ○ **P**=Pins & Needles ○ **S**=Stabbing ○ **O**=Other



*****PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT*****

1020 PARK AVENUE, NEW YORK, NY, 10029
TEL: 212-249-6767 FAX: 212-861-4769

1. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your life time? ○ YES ○ NO If so, when: _____

2. When was your last spinal Examination including X-rays? _____ ○ NEVER

3. Have you ever been told that you have pinched nerve, spinal curvature, spinal arthritis, or inherited spinal problem? ○ YES ○ NO If so, when: _____

4. Subluxation or spinal misalignment cause decay and degenerative which result in grinding or cracking. Do you ever hear noises when you move your head, neck, low back or hips? ○ YES ○ NO

5. Spinal misalignments or subluxations can make you feel like you need to twist, stretch or crack your neck and back. Do you ever feel the need to "crack and pop" your neck or lower spine? ○ YES ○ NO

6. Poor posture leads to poor health, and often indicates a spinal problem and pinched nerve. How would you rate your posture?

POOR 1 2 3 4 5 6 7 8 9 10 **EXCELLENT**

7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

LOW 1 2 3 4 5 6 7 8 9 10 **HIGH**

8. Chiropractic care is for optimal health and healing. What health concerns or crisis brought you to our office?_____
_____

9.Prescription medications may hide the severity of health problems, and hinder the body's ability to heal. What Medications are you currently taking? _____

10. Slips & falls, motor vehicle accidents & sports injuries can cause serious spinal problems (even if not reported). Have experienced any trauma? ○ YES ○ NO If so, when: _____

PAST HELATH HISTORY – Pleas fill out carefully as these problems can affect your overall course of care.

Childhood Illness:

○ ADD	○ ALLERGIES/HAYFEVER	○ ASTHMA	○ ATOPIC DERMATITIS	○ CEREBRAL PALSY	○ CHICKEN POX
○ DEPRESSION	○ DIABETES	○ FETAL DRUG EXPOSURE	○ FOOD ALLERGIES	○ HEADACHES	○ HEPATISIS
○ MEASLES	○ MUMPS	○ RASH	○ SEIZURE DISORDER	○ SICKLE CELL ANEMIA	○ SPINA BIFIDA
○ UNUSUAL CHILDHOOD ILLNESS		○ **NONE**			

Adult Illness:

○ ANEMIA	○ ARTHRITIS	○ ASTHMA	○ CANCER	○ CHICKEN POX	○ CRPS (RSD)
○ CVA(STROKE)	○ DEPRESSION	○ DIABETES	○ EYE PROBLEMS	○ HEART DISEASE	○ HEPATITIS
○ HYPERTENSION	○ KIDNEY DISEASE	○ LIVER DISEASE	○ LUNG DISEASE	○ PSHYCHIATRIC PROBLEMS	○ SEIZURES
○ STD'S	○ SUICIDE ATTEMPTS	○ THYROID PROBLEMS	○ **NONE**		

Surgeries:

○ ANGIOPLASTY	○ APPENDECTOMY	○ CAESAREAN SECTION	○ CARDIAC CATHETERIZATION	○ CARPAL TUNNEL REPAIR
○ CORONARY BYPASS	○ COSMETIC	○ D & C	○ HEMORRHOIDECTOMY	○ HERNIA REPAIR
○ HYSTERECTOMY	○ JOINT RECONSTRUCTION	○ JOINT REPLACEMENT	○ LAMINECTOMY	○ MASTERECTOMY
○ PACEMAKER INSERTION	○ SPINAL FUSION	○ TONSILECTOMY	○ **OTHER:**	○ **NONE**

Immunizations:

○ FLU	○ HEPATITIS A	○ HEPATITIS B	○ HEPATITIS C	○ MNR	○ PNEUMONIA
○ PPD	○ SMALL POX	○ TD	○ VARIVAX	○ **NONE**	○ **ALL**
○ COVID 19 : NAME:		1ST DOSAGE		2ND DOSAGE	

Injuries: Describe_____

○ **NONE**

OB/GYN**:** Describe _____

○ **NONE**

Non-Drug Allergies: Describe _____

○ **NONE**

Family History: Alive Deceased

	ALIVE	DECEASED	CONDITION:
GENERAL FAMILY	○	○	
MOTHER	○	○	
FATHER	○	○	
PATERNAL GRANDMOTHER	○	○	
PATERNAL GRANDFATHER	○	○	
MATERNAL GRANDMOTHER	○	○	
MATERNAL GRANDFATHER	○	○	
SON(S)	○	○	
DAUGHER(S)	○	○	
BROTHER(S)	○	○	
SISTER(S)	○	○	

Social History:

Diet: ○ HIGH FAT DIET ○ HIGH FIBER ○ HIGH PROTEIN ○ HIGH SALT INTAKE
○ LOW CALORIES INTAKE ○ LOW CARBOHYDRATE ○ LOW FIBER ○ LOW SUGAR

Alcohol: ○ **NONE** ○ BEER ○ LIQUOR ○ SOCIAL CONSUMPTION ○ WINE ○ AMOUNT _____

Tobacco: ○ YES ○ NO Marijuana / CBD: ○ YES ○ NO

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Other doctors seen for this condition? ○ YES ○ NO Who? _____
Type of Treatment? _____ Results: _____
Drugs you now take: ○ Nerve Pills ○ Pain Killers ○ Muscle Relaxers ○ Blood Pressure Medicine ○ Insulin
○ Allergy Medicine ○ Anti-Depressants ○ Other: _____
Do you wear Heel Lifts? ○ YES ○ NO Side Lift ○ YES ○ NO Inter Soles ○ YES ○ NO Arch Supports ○ YES ○ NO Orthotics ○ YES ○ NO
Any other conditions you feel we should know about- even if unrelated? _____
_____

Below is a list of diseases which 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. Review of systems- pleas fill out all sections even if "NONE"

CONSTITUTIONAL: ○ NONE

○ CHILLS	○ DAYTIME SOMNOLENCE	○ FATIGUE	○ FEVER	○ NIGHT SWEATS	○ WEIGHT GAIN
○ WEIGHT LOSS					

EYES/VISION: ○ NONE

○ BLINDNESS	○ BLURRED VISION	○ CATARACTS	○ CHANGE IN VISION	○ DOUBLE VISION	○ EAR DRAINAGE
○ FIELD CUTS	○ GLASSES/CONTACTS	○ GLAUCOMA	○ ITCHING	○ PHOTOPHOBIA	○ TEARING

RESPIRATION: ○ NONE

○ ASTHMA	○ COUGH	○ COUGHING UP BLOOD	○ SHORTNESS OF BREATH	○ SPUTUM PRODUCTION	○ WHEEZING

ENT: ○ NONE

○ BLEEDING	○ DENTURES	○ DIFFICULY SWALLOWING	○ DISCHARGE	○ DIZZINESS	○ EAR DRAINAGE
○ EAR PAIN	○ FAINTING	○ FREQ. SOAR THROAT	○ HEADACHES	○ HEARING LOSS	○ HEAD INJURY
○ HOARSENESS	○ LOSS OF SMELL	○ NASAL CONGESTION	○ NOSE BLEEDS	○ POST NASAL DRIP(PNS)	○ RHINORRHEA
○ SINUS INFECTIONS	○ SNORING	○ TINNITUS/RINGING EARS	○ TMJ		

CARDIO: ○ NONE

○ ANGINA	○ CHEST PAIN	○ CLAUDICATION	○ HEART MURMUR	○ HEART PROBLEMS	○ ORTHOPNEA
○ PALPITATIONS	○ PND	○ SOB WITH EXERTION	○ SWELLING OF LEGS	○ ULCERS	○ VARICOSE VEINS

GASTRO: ○ NONE

○ ABDOMINAL PAIN	○ BELCHING	○ BLACK TARRY STOOLS	○ CONSTIPATION	○ DIARRHEA	○ DIFFICULTY SWALLOWING
○ HEART BURN	○ HEMORRHOIDS	○ INDIGESTION	○ JAUNDICE	○ NAUSEA	○ RECTAL BLEEDING
○ REGURGITATION	○ STOOL CALIBER	○ STOOL COLOR	○ STOOL CONSISTENCY	○ VOMITING	○ VOMITING BLOOD

FEMALE: ○ NONE

○ BREAST LUMPS	○ BREAST PAIN	○ BURNING URINATION	○ CRAMPS	○ FREQUENT URINATION	○ IRREGULAR MENSTRUATION
○ URINE RENTENTION	○ VAGINAL BLEEDING	○ VAGINAL DISCHARGE	○	○	○

MALE: ○ NONE

○ BURNING URNINATION	○ ERECTILE DYSFUNCTION	○ FREQUENT URINATION	○ HESITANCY/DRIBBLING	○ PROSTATE	○ URINE RETENTION

ENDOCRINE: ○ NONE

○ COLD INTOLERANCE	○ DIABETES	○ EXCESSIVE APPETITE	○ EXCESSIVE HUNGER	○ EXCESSIVE THIRST	○ FREQUENT URINATION
○ GOITER	○ HAIR LOSS	○ HEAT INTOLERANCE	○ UNUSUAL HAIR GROWTH	○ VOICE CHANGES	

SKIN: ○ NONE

○ CHANGE IN NAIL TEXTURE	○ CHANGE IN SKIN COLOR	○ HAIR GROWTH	○ HAIR LOSS	○ HIVES	○ ITCHING
○ PARESTHESIAS	○ PRURITIS	○ RASH	○ SKIN DISORDER	○ SKIN LESSIONS/ULCERS	○ VARICOSITIES

NERVOUS: ○ NONE

○ DIZZINESS	○ FACIAL WEAKNESS	○ HEADACHE	○ LIMB WEAKNESS	○ LOSS OF CONSCIOUSNESS	○ LOSS OF MEMORY
○ NUMBNESS	○ SEIZURES	○ SLEEP DISTURBANCE	○ SLURRED SPEECH	○ STRESS	○ STROKES
○ TREMOR	○ UNSTEADINESS OF GAIT	○	○	○	○

PHYCHOLOGIC: ○ NONE

○ ANHEDONIA	○ ANXIETY	○ APPETITE	○ BEHAVIORAL CHANGE	○ BIPOLAR	○ CONFUSION
○ DEPRESSION	○ INSOMNIA	○ MEMORY LOSS	○ MOOD CHANGE	○	○

ALLERGY: ○ NONE

○ ANAPHALAXIS	○ FOOD INTOLERANCE	○ ITCHING	○ NASAL CONGESTION	○ SNEEZING	○

HEMATOLOGY: ○ NONE

○ ANEMIA	○ BLEEDING	○ BLOOD CLOTTING	○ BLOOD TRANSFUSION	○ BRUSING	○ FATIGUE
○ LYMPH NODE SWELLING	○	○	○	○	○

CONDITION'S EFFECT ON JOB PERFORMANCE:

CARE-INFIRM FAMILY	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)

DAILY ACTIVITIES: EFFECTS OF CURRENT CONDITIONS ON PERFORMANCE:

CARE-INFIRM FAMILY	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
CARRYING GROCERIES	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
CHANGE POS-SIT-STAND	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
CLIMB STAIRS	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
DAILY PET CARE	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
DRIVING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
EXT COMPUTER USE	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
HOUSEHOLD CHORES	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
LIFT CHILDREN	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
SELF CARE-BATHING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
SELF CARE- DRESSING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
SELF CARE- SHAVING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
SEXUAL ACTIVITIES	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
SLEEP	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
STATIC SITTING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
STATIC STANDING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
WALKING	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
YARD WORK	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)

RECREATIONAL ACTIVITY: EFFECTS OF CURRENT CONDITION ON PERFORMANCE

	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)
	○ **NO EFFECT**	○ **MILD** PAINFUL (CAN DO)	○ **MOD** PAINFUL (LIMITED)	○ **SEV** PAINFUL (UNABLE TO PERFROM)

PATIENT SIGNATURE: ____ **TODAY'S DATE:** ___________________________________

RELATIONSHIP: ____

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