

TOTAL HEALTH WELLNESS CENTER

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Kelly L. Hubbard, D.C.

Confidential Patient Health Record

Patient Name:	DOB:	Exam Date:
Who referred you to us?		File #:
Occupation:	Previous Chiropractic Care?	

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS:

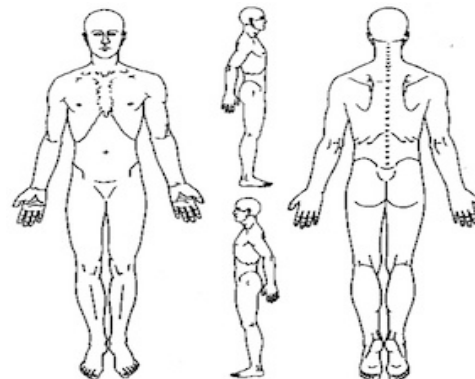
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Headache Neck Pain Mid-Back Pain Low Back Pain
Other _____

Is this? Work Related Auto Related N/A

Date Problem Began: _____

How Problem Began: _____



Current complaint (how you feel today):
| _____ |
No Pain 1 2 3 4 5 6 7 8 9 Unbearable

How often are your symptoms present?

(Occasional) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (work, socializing, household activities)

| _____ |
No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Briefly describe any additional information regarding your condition: _____

Does bed rest make your symptoms: Better Worse No effect

How long do your symptoms last? _____

What symptoms did you first notice? _____

Have you seen other Doctors for this condition? No Yes (Who & when) _____

Spinal X-Rays MRI CT Scan? (Please circle) Date/Areas of complaint taken? _____

Since the initial onset, have you done anything to make your condition worse? No Yes (Describe) _____

Any past Auto Accidents? No Yes (Describe) _____

Please check all of the following that apply to you, or that you are currently taking or using:

- Alcohol/Drug Dependence Recent Fever Diabetes High Blood Pressure Blood Pressure Medication
- Stroke (Date) _____ Aspirin Birth Control Pills Dizziness/Fainting Numbness in Groin/Buttocks
- Cancer/Tumor (Explain) _____ Prostate Problems Menstrual Problems
- Urinary Problems Currently Pregnant, # of weeks: _____ Abnormal Weight Gain Loss
- Marked Morning Pain/Stiffness Pain Unrelieved by Position or Rest Pain at Night Visual Disturbances
- Osteoporosis Epilepsy/Seizures Surgeries: _____
- Tobacco Use – Type: _____ Frequency: _____/Day Medications: Insulin Nerve Pills
- Corticosteroid Use (Cortisone, Prednisone, etc) Antidepressants Blood Pressure Medication Vitamins
- and/or Supplements: _____ Pain Killers/Muscle Relaxants Shoe Lifts Other: _____

Hospitalizations: _____

Allergies: _____

Doctor's name & date of last physical exam: _____

Family History: Cancer Diabetes High Blood Pressure Heart Problems Stroke Rheumatoid Arthritis