CATHEY CHIROPRACTIC

Confidential Patient Health Information

Personal Information:

☐ Mr. ☐ Mrs. ☐ Miss Name: _____

Address: _____City/ST: _____ZIP:_____

SS#: _____/_____/_____ Birthdate: ___ /____/____ Age: _____

Marital Status: M W Sep. D Sin. Spouse Name: _____ No. of Children: _____

Home Phone: ( ) ____-_____ Work Phone: ( ) _____-_____X____ Other Phone ( ) _____-_____

Employer: _____Occupation: _____ How Long? _____

E-mail address (for Patient newsletter):_____

HOW WERE YOU REFERRED?_____

Reason for your Visit:

Purpose of this appointment_____

Reason for your visit is a result of (please circle): work injury, auto accident, trauma, chronic problem, other

Please describe the pain and its location: _____

Date of accident/injury, or when condition began: _____/_____/_____

Is condition getting worse? ☐ Yes ☐ No ☐ Staying the Same ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Have you been treated by another doctor for this condition? ☐ Yes ☐ No

If yes, please name doctor/health care facility: _____

Is there any chance that you are pregnant? ☐ Yes ☐ No Estimated due date: _____

CATHEY CHIROPRACTIC

Confidential Patient Health Information

Your Health History (circle "C" if the problem is a current one and "P" if you've had the problem in the past)

General
C P Allergy
C P Convulsions
C P Fatigue
C P Fainting
C P Headache
C P Sudden Weight Loss
C P High Blood Pressure

Muscle & Joint
C P Arthritis
C P Bursitis
C P Low Back Pain
C P Neck Pain/Stiffness
C P Shoulder Pain
C P Spinal Curvature
C P Midback Pain

Eyes, Ears Nose & Throat
C P Hearing Loss
C P Ear-ache
C P Failing Vision
C P Nosebleeds
C P Sinus Infections
C P Strep Throat
C P Thyroid Problems

Gastrointestinal
C P Colon Problems
C P Constipation
C P Diarrhea
C P Gall Bladder
C P Hemorrhoids
C P Hernia
C P Liver Problems

Vascular
C P Nausea/Vomiting
C P Dizziness
C P Numbness on one side of the face or body
C P Difficulty Swallowing
C P Difficulty Walking
C P Difficulty Speaking
C P Fainting/Light Headed
C P Double Vision
C P Rapid Eye Movement
C P Neck or Head Pain

Pain or Numbness
C P Shoulders/Arms
C P Elbows/Hands
C P Hips/Legs
C P Ankles/Knees/Feet

Genito-Urinary
C P Bedwetting
C P Frequent Urination
C P Kidney Infection
C P Painful Urination
C P Prostate Trouble
C P Kidney Stones

Skin Problems
C P Bruise Easily
C P Hives or Allergic Reaction
C P Skin Rash
C P Acne

For Women Only
C P Cramps or Backache w/cycle
C P Excessive Menstral Flow
C P Irregular Cycles
C P Lumps in Breast
C P Pelvic Inflammatory Disease

Respiratory
C P Asthma
C P Chest Pain
C P Chronic Cough
C P Spitting up Blood

Other
C P Stroke
C P Rheum.Fever
C HIV/AIDS
C P Alcoholism
C P Diabetes
C P Cancer

Please list any medications you are taking, (including OTC)_____

Please list any medications that you are allergic to: _____

Please list all surgeries and dates_____

_____

Medical Physician's name_____

Your Family History (some health problems are the result of familial tendencies)

Illnesses

Father_____
Mother_____
Brother(s)_____
Sister(s)_____

Social History

Do you smoke? ☐ Yes ☐ No If yes, how may packs per day? _____ For how long?_____
Do you consume alcoholic beverages? ☐ Yes ☐ No If yes, socially? Moderately? Daily? Rarely?
Do you exercise regularly? ☐ Yes ☐ No If yes, daily? 3x/week 1x/week Other (specify): _____

In the event of an emergency…

Who should we contact? _____ Relationship: _____

Home Phone #: ( ) _____-_____ Work Phone #: ( ) _____-_____ X _____

713 West Alameda St. - Roswell, New Mexico 88203 – Telephone (575) 622-0902