Daniel Ryan, D.C.

Confidential Patient Health Record

PLEASE PRINT CLEARLY:

Date:_____

Name:_____ Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____ Birth Date:_____ Age:_____ Sex: M F

E-mail Address _____

Shipping Address _____

_____

Social Security #:_____ Drivers License Number:_____

Business Employer: _____ Circle one: Single Married Divorced Widowed Separated

Business Phone: _____ Type of Work: _____

Name of Spouse:_____ Spouse's Social Security #:_____

Spouse's Employer:_____ Business Phone:_____

Type of Work:_____

Referred to this office by:_____

Name and Number of Emergency Contact: _____

CURRENT HEALTH CONDITION

Overall health (circle one): Excellent / Good / Fair / Poor / Other _____

Chief Complaint (reason you are here) (use a separate sheet if more room is needed):_____

_____

Office Use Only:

Other doctors seen for this condition? _____ Yes _____ No

Who? _____Type of treatment:_____

Results:_____ When did this condition begin? _____

Has this condition occurred before? ____ Yes ____ No Do you wear a shoe lift? ____ Yes ____ No Orthotics? ____Yes ____ No

MEDICAL HISTORY

Check any of the following you or your relatives have had:

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Heart Trouble	Hypothyroidism	Kidney Trouble	Nervous Breakdown	Stomach Ulcer	Stroke	Ulcer
You													
Father													
Mother													
Brother													
Sister													
Spouse													
Children													
Grandparents													

Check any other illnesses you have had:

____ Anemia ____ eye disease ____ gall stones ____ thyroid disease ____ polio

____ eczema ____ hemorrhoids ____ liver ____ chicken pox ____ rheumatic fever

____ bronchitis ____ hepatitis ____ malaria ____ measles ____ jaundice

____ diverticulosis ____ hernia ____ mumps ____ mononucleosis ____ herpes

____ emphysema ____ pancreatitis ____ HIV

Check any tests of immunizations you have ever had and the year you had them:

( )	year	test
___	_____	chest X-ray
___	_____	kidney x-ray
___	_____	G.I. series
___	_____	colon x-ray
___	_____	gall bladder x-ray
___	_____	electrocardiogram
___	_____	T.B. Test
___	_____	other x-rays
_____		

( )	year	Immunization
___	_____	small pox
___	_____	tetanus
___	_____	polio
___	_____	typhoid
___	_____	flu
___	_____	mumps
___	_____	measles
___	_____	overseas
___	_____	others

Allergies you have:

Food:_____

Animals:_____

Drugs:_____

Please check and describe:

Major Surgery/Operations: ____ Appendectomy ____ tonsillectomy ____ Gall Bladder ____ Hernia ____ Back Surgery

____ Broken Bones ____ Other:_____

Major Accidents or falls:_____

Have you ever been hospitalized (other than above):_____

Previous chiropractic Care: _____ None If yes, Doctor's Name and Approx. Date of Last Visit:_____

Acupuncture Care: _____ None If yes, Acupuncturist's Name and Approx. Date of Last Visit:_____

Other healthcare physician: _____ None If yes, Doctor's Name and Aprox. Date of Last Visit:_____

Describe health of spouse: _____ Number of children if any _____

Name of child	Age	Sex	Any physical conditions or concerns?
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

Any household pets or other animals you or family members are in close contact with:

_____

SUBSTANCE SURVEY

Please list any prescription medications you are currently taking or have taken in the last year:

Medications	Diagnosis

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity and Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year. (Use other side of needed).

Product	Symptom	Quantity and Frequency

Have you ever taken:

_____ Birth control pills _____ Thyroid Pills _____ Estrogen (Premarin, etc.)

_____ Allergy shots _____ Antibiotics _____ Cortisone/prednisone

_____ Other hormone shots _____ Other (please explain):_____

Do you wear contacts?_____ Pacemaker?_____

Have you ever had a hair analysis?_____ If so, when?_____

DIET

Check the following items which apply to you and indicate the amount used:

_____ coffee _____ alcohol _____ tea _____ soft drinks _____ candy _____ Artificial sweetener _____ antacids

_____ laxatives _____ Ice cream _____ cigarettes _____ other tobacco products

LIFE STYLE

How much time do you spend outside everyday?_____

Do you usually wear sunglasses when you are outside?_____

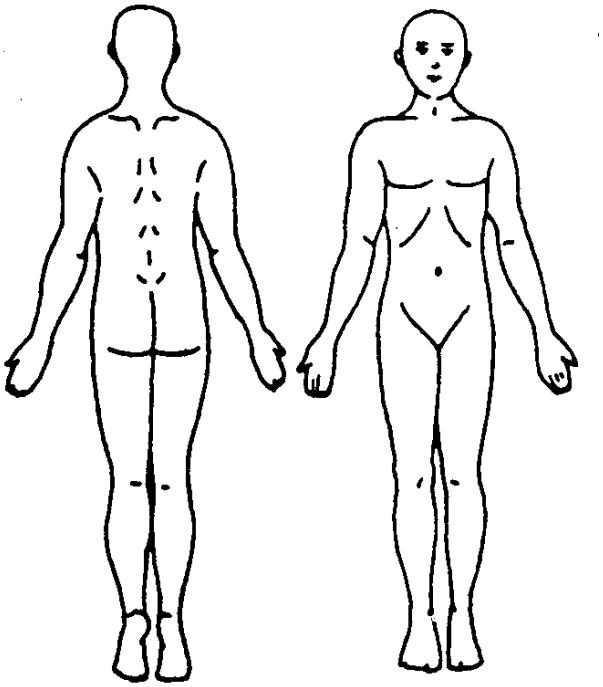
How often do you watch t.v.?_____

How often do you exercise?_____

Describe the type of exercise._____

_____

What other type of exercise do you enjoy?_____



Please outline on the diagram the area of your discomfort

SYMPTOMS REVIEW

Directions: Circle any of the following symptoms that have bothered you in the past 6 months. Please comment in the space provided about frequency, time of last occurrence, duration, inciting events, etc…

SYMPTOMS			COMMENTS
Head			
Headaches	sore scalp/dandruff		
Dizziness	hair loss		
Eyes			
Dry eyes	excessive tearing		
Red eyes	double vision		
Blurred vision	other vision problems		
Ears			
Poor hearing	ear ringing		
Earaches	deafness		
Ear discharge	other ear problems		
Mouth			
Bleeding gums	ulcers	sore tongue	
Herpes sores	dry lips	dry mouth	
Throat			
Sore throats	difficulty swallowing		
Tonsillitis	spitting up mucus often		
Hoarseness			
Skin			
Rash	pigment changes		
Dryness	changing moles or lumps		
Itching	abnormal sweating		

SYMPTOMS COMMENTS

Intestines

Dry (hard) stool	loose or watery stool
Blood in stool	mucus in stool
Stool painful to pass	abnormal stool color
Use laxatives often	use fiber to help w/ constipation

Urinary

Loss of force of urine stream	change in quantity of urine
Hesitancy to urinate	need to urinate at night
Urination w/ sneeze or cough	

How often do you urinate each day?_____

Reproduction

Excessive sexual drive	genital herpes
Other Sexually transmitted disease	

Frequency of intercourse?_____Method of birth control?_____

Men

Premature ejaculation	discharge from penis
Impotence	low sperm count
Seminal emission	difficulty keeping erection
Prostate problems	pain/coldness in genital area

Women

Vaginal pain	vaginal bumps or sores
Vaginal dryness	discharge from nipples
Cannot get pregnant	

Menses

No menstrual period	heavy blood flow
Spotting between periods	light blood flow
Blood clots with flow	

Are you or might you be pregnant?_____# of pregnancies?_____

How many days apart are your periods?_____# of abortions?_____

Length of periods?_____ # of live births?_____ # of miscarriages?_____

Endocrine

Neck enlargement	hair or nail changes
Intolerance to heat or cold	

Neurological

Nervousness	numbness or tingling of hands/feet
Tremors or shaking	convulsions
Incoordination	paralysis
Drowsiness	memory changes
Nerve pain (neuralgia)	

Musculoskeletal

Arthritis	muscular weakness
Swelling of joints	deformity
Stiff neck	Temporal mandibular joint (TMJ) Pain

Sleep

Wake up tired	nightmares

# of hours of sleep per night?_____

Job related

Feel bored in my work	frustrated at work
Want to change jobs	too much pressure at work
No challenge at work	work often difficult

Emotional health

Frequent stress	often feel irritable	often feel lonely	often feel unmotivated
Mood swings	often feel happy	often feel sad	
Often feel angry	often feel guilty	often feel overworked	

SYMPTOMS		COMMENTS
General		
Abnormal weight gain	unexplained fever or chills	
Abnormal weight loss	loss of feeling of well being	
Fatigue	overweight/underweight	

List the problems below that concern you the most, in order of importance.

1. 4.

2. 5.

3. 6.

Dental history

Do you currently need dental work?_____ If so, what?_____

# of fillings?_____ Type? (amalgam, gold, resin, etc.)_____

# of teeth pulled?_____ Do you wear dentures or partials?_____

Scars

Do you have any major scars anywhere on your body? _____ If so, where? _____

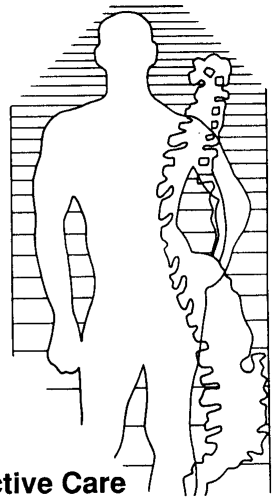
_____

_____

If this is an accident related injury, please fill out the Accident Form. Thank You!

Relief Care

Relief care is that necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in its length or time, but is more lasting.

Please check the type of care desired so that we may be guided by your whishes whenever possible.

_____ Relief care _____ Corrective care _____ Check here if you want the doctor to select the type of care appropriate for your condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare a superbill that I can submit to my health insurance. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time the services are provided.
I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine, acupressure, myotherapy and nutritional/herbal support. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature **X**_____ Date_____

Guardian or Spouse's
Signature Authorizing Care_____ Date_____