Confidential Patient Health Record

Today's Date: ___/___/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs.

Last:_____ First:_____ Middle: _____

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III

Birth Date: ___ /___/_____ Age:_____ Sex: Male / Female SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ Country: _____ County: _____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____ Fax #: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ First:_____Middle:_____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Home Phone: (_____) _____-_____ ext _____ Cell Phone: (_____) _____-_____ ext ___

Work Phone: (_____) _____-_____ ext _____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

_____

Chief Complaint – HPI (History of Present Illness)

Patient Name: _____ Case: _____ Date: _____ Dr: _____

Chief Complaint and Occurrence:

_____

_____

_____

_____

Body Area(s) Involved: ☐ Cervical ☐ Spine, Ribs, Pelvis ☐ Upper Extremity ☐ Lower Extremity

Condition: ☐ New → ☐ Acute or ☐ Chronic

☐ Recurrence (Acute) ☐ Exacerbation (Acute) ☐ Chronic

Mechanism of Onset:

☐ Auto: ☐ Driver/Passenger ☐ Pedestrian (refer to completed auto accident history form)
☐ Work Related: ☐ Fall ☐ Falling Object ☐ Lifting ☐ Overexertion ☐ Repetitive Motion ☐ Other: _____
☐ Other – Liability: ☐ Slip or Fall ☐ Other: _____
☐ Other – No Liability: ☐ Etiology Unknown ☐ Overexertion ☐ Repetitive Use ☐ Slept Wrong ☐ Slip or Fall
☐ No Injury

Description of Onset of Complaint: _____

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: Left / Right / Bilateral _____

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

Level of Impairment Due to Symptoms (Resting):

0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):

0 1 2 3 4 5 6 7 8 9 10

Duration: Started: _____

Last Occurred: _____ Last episode: _____ Resolved Previous Visit: _____
Worsened: _____ Injury Occurred: _____ Accident Occurred: _____

Timing: *Worse*: ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Intermittent

Context: *Better with:* ☐ Warm Temp ☐ Cold Temp *Worse with:* ☐ Warm Temp ☐ Cold Temp ☐ Damp

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing
☐ Localized Tingling ☐ Nausea ☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Headaches: Location: ☐ Occipital ☐ Frontal ☐ Left Temporal ☐ Right Temporal ☐ Parietal ☐ Sinus
Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Aura ☐ No Aura
Types: ☐ Hat Band ☐ Cluster ☐ Migraine ☐ Tension
Other: (frequency/duration/time of day) _____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

Other Assoc Signs and Symptoms:

☐ aches	☐ burning	☐ cold limb(s)	☐ difficulty walking	☐ dizziness
☐ ecchymosis	☐ chronic fatigue	☐ fever	☐ heartburn	☐ joint stiffness
☐ muscle spasm	☐ muscle weakness	☐ nausea	☐ numbness	☐ pale bluish skin
☐ panic	☐ pins & needles	☐ rhinorrhea (runny nose)	☐ shortness of breath	☐ sweating
☐ swelling	☐ tingling	☐ vomiting		

Chief Complaint – HPI (History of Present Illness)

Patient Name:_____ Case:_____ Date:_____Dr:_____

Previous Hospitalizations/Surgeries/Serious Illnesses: When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription)_____

_____

_____

Patient social history:

Marital status: Single:_____ Married:_____ Separated:____ Divorced:_____ Widowed:____

Use of alcohol: Never:_____ Rarely:_____ Moderate:____ Daily:_____

Use of tobacco: Never:_____ Previously, but quit:_____ Current packs/day:_____

Use of drugs: Never:_____ Type/Frequency:_____

Excessive exposure at home or work to: Fumes:_____ Dust:_____ Solvents:_____ Air-borne Particles:___
Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

_____

_____

_____

_____

_____

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_____

FACCA CHIROPRACTIC CLINIC

PATIENT NAME _____ **Patient #** _____ **DATE** _____

CHECKLIST: Review of Systems

GENERAL

- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

SKIN

- ☐ Rashes
- ☐ Lumps
- ☐ Dryness
- ☐ Itching
- ☐ Color changes
- ☐ Hair and nail changes

HEAD

☐ Headache ☐ Head injury

EARS

- ☐ Decreased hearing
- ☐ Earache
- ☐ Ringing in ears (tinnitus)
- ☐ Drainage

EYES

- ☐ Vision
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Flashing lights
- ☐ Blurry or double vision
- ☐ Specks
- ☐ Cataracts
- ☐ Last eye exam
- ☐ Glaucoma
- ☐ Redness

NOSE

- ☐ Stuffiness
- ☐ Discharge
- ☐ Hay fever
- ☐ Itching
- ☐ Sinus pain
- ☐ Nosebleeds

THROAT

- ☐ Teeth
- ☐ Gums
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores
- ☐ Last dental exam

NECK

- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

BREASTS

- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

RESPIRATORY

- ☐ Cough (dry or wet, productive)
- ☐ Coughing up blood (hemoptysis)
- ☐ Wheezing
- ☐ Shortness of breath (dyspnea)
- ☐ Sputum (color and amount)
- ☐ Painful breathing

CARDIOVASCULAR _____

- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations
- □ Swelling (edema)
- □ Difficulty breathing lying down (orthopnea)
- □ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)
- □ Shortness of breath with activity (dyspnea)

GASTROINTESTINAL _____

- □ Swallowing difficulties
- □ Heartburn
- □ Change in appetite
- □ Nausea
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea
- □Yellow eyes or skin (jaundice)

URINARY _____

- □ Frequency
- □ Urgency
- □ Blood in urine (hematuria)
- □ Incontinence
- □ Burning or pain
- □ Change in urinary strength

VASCULAR _____

- □ Calf pain with walking (Claudication)
- □ Leg cramping

MUSCULOSKELETAL _____

- □ Muscle or joint pain
- □ Swelling of joints
- □ Trauma
- □ Redness of joints
- □ Stiffness
- □ Back Pain

NEUROLOGIC _____

- □ Dizziness
- □ Fainting
- □ Seizures
- □ Weakness
- □ Numbness
- □ Tingling
- □ Tremor

HEMATOLOGIC _____

- □ Ease of bruising
- □ Ease of bleeding

ENDOCRINE _____

- □ Head or cold intolerance
- □ Sweating
- □ Frequent urination (polyuria)
- □ Thirst (polydipsia)
- □ Change in appetite (polyphagia)

PSYCHIATRIC _____

- □ Nervousness
- □ Depression
- □ Memory Loss
- □ Stress

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and inference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than Vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,_____ have read and fully understand the above statements. (Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

Consent to evaluate and adjust a minor child

I,_____ being the parent or legal guardian of _____ Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform a x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

_____ _____

(Signature) **(Date)**

Facca Chiropractic Clinic
Dr. Robert Facca
35046 Woodward Ave. Suite L14
Birmingham, MI 48009
248-545-1550

Fee Notification

I have elected to receive services from Facca Chiropractic Clinic and agree to pay for these services. I understand that these services are rendered to the patient, not the insurance companies. The insurance company is responsible to the patient who holds the contract.

I understand that with or without insurance coverage for Chiropractic Care I am fully responsible for fees incurred from services received at Facca Chiropractic Clinic.

I also understand that my Co-pay/Payment is due at time of service.

Date_____

Patient Signature _____

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that **FACCA CHIROPRACTIC CLINIC'S** Notice of Privacy Practices has been provided to me.

I understand I have a right to review Dr. Facca's Notice of Privacy Practices prior to signing this document. Dr. Facca's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of **FACCA CHIROPRACTIC CLINIC**. The Notice of Privacy Practices for **FACCA CHIROPRACTIC CLINIC** is also provided on request at the main administration desk. This Notice of Privacy Practices also describes my rights and **FACCA CHIROPRACTIC CLINIC'S** duties with respect to my protected health information.

FACCA CHIROPRACTIC CLINIC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority