

# MARKET PLACE CHIROPRACTIC WELLNESS CENTER PATIENT HEALTH RECORD

## ABOUT THE PATIENT

Name: First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender  M  F

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Driver's License # \_\_\_\_\_

Social Security # \_\_\_\_\_

Marital Status:  Married  Single  Divorced

Separated  Widowed

## ABOUT THE SPOUSE OR PARENT

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Insurance Holder Date of Birth: \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

How did you hear about our office?  Phone Book  Paper

Internet (site) \_\_\_\_\_

Patient referral (name) \_\_\_\_\_

Other referral source \_\_\_\_\_

Have you been adjusted by a chiropractor before?

No  Yes

Reason for those visits: \_\_\_\_\_

Previous Chiropractor's Name: \_\_\_\_\_

Approximate Date of Last Adjustment: \_\_\_\_\_

## REASON FOR TODAY'S VISIT

What is the purpose of today's visit? \_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Is this condition  Getting better?

Getting worse?

Staying the same?

Have you had this condition before?  Yes  No

What does this condition prevent you from doing? \_\_\_\_\_  
\_\_\_\_\_

Other Doctors or Health Care Providers seen for this condition: \_\_\_\_\_

Type of Treatment given: \_\_\_\_\_

What were the Results? \_\_\_\_\_

## LIFESTYLE & WELLNESS HABITS

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant Hand: \_\_\_\_\_

Exercise:  Seldom  \_\_\_\_\_X per week  Daily

How many servings of fresh Fruits & Vegetables do you eat per day? \_\_\_\_\_

How much water do you drink every day? \_\_\_\_\_

Do you take Whole Food supplements?  No  Yes

Do you take Omega-3 fatty acid supplements?  No  Yes

Do you take Probiotics?  No  Yes

Do you smoke or use tobacco?  No  Yes

Do you drink alcohol?  No  Yes \_\_\_\_\_X per week

Do you use products containing Aspartame?  No  Yes

Do you wear orthotics or shoe inserts?  No  Yes

Please list ALL Medications, Drugs, Vitamins or

Supplements you take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HEALTH HISTORY

Please check ALL conditions you have NOW or in the PAST

	NOW	PAST		NOW	PAST		NOW	PAST
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY</b>		
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Do you take oral birth control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you have breast implants?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>	Do you have painful periods?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Leg/Foot Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Do you have irregular cycles?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

## SURGERIES

Spinal     Sinus     Tonsils     Throat     Thyroid     Colon     Stomach   
 Appendix     Gallbladder     Hysterectomy     Other \_\_\_\_\_

## GOALS FOR CHIROPRACTIC CARE

- "PATCH CARE"**    Symptomatic Relief of your pain or other symptoms
  
- "FIX CARE"**    Correcting the underlying cause of your symptoms and problems with Chiropractic care
  
- COMPREHENSIVE WELLNESS CARE**    Working with your innate genetic intelligence to bring the function of the body to its optimum state of health & well being with Chiropractic care, Nutrition, Detoxification, Exercise, etc., as clinically indicated.

## AUTHORIZATION FOR CHIROPRACTIC CARE

I hereby authorize Market Place Chiropractic Wellness Center, PLLC, Dr. Jeffrey P. Clark, or whomever he may authorize to work with my condition through the use of chiropractic adjustments and any necessary ancillary care as is deemed appropriate. I agree that I will not hold Market Place Chiropractic Wellness Center, PLLC, or Dr. Jeffrey P. Clark, responsible for any pre-existing medically diagnosed condition(s) nor for any medical (non-chiropractic) diagnosis. Any X-Rays taken of my spine are permanent records of Dr. Jeffrey P. Clark, dba: Market Place Chiropractic Wellness Center, PLLC, and will remain on file in accordance to State Law.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Parent or legal guardian if patient is under 18 years old. Please PRINT your name and relationship to patient in space below.)