**CONFIDENTIAL PATIENT HEALTH RECORD**

| DATE | FILE NO. |
|---|---|
| | |

## PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Birth Date: _____ Age: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____ Sex: ☐ M ☐ F

Social Security _____ Driver's License No. _____ Email Address: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type of Work: _____

Business Address: _____

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

Type of Work: _____

Business Phone: _____

Names and Ages of Children: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare

Personal Health Insurance (Name) _____ ☐ Health Card # _____

## CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

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

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Your Auto Insurance Company: _____ Time of Accident: _____

Have You Made a Report of Your Accident To Your Employer? ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers / Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin
☐ Other _____

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

## PAST HEALTH HISTORY

| HOSPITALIZATIONS | | | PREGNANCY HISTORY | | |
|---|---|---|---|---|---|
| Year | Hospital | Reason for Hospitalization and outcome | Year of Birth | Sex of Birth | Complications, if any |
| | | | | | |
| | | | | | |
| | | | | | |

Major Accident or Falls: _____

_____