MARKET PLACE CHIROPRACTIC WELLNESS CENTER
PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name: First_______________Initial____Last_________________

Address:____

City____

Date of Birth:______________Age:_____Gender ☐ M ☐ F

Home Phone:_________________________________
____

Cell Phone:____

Cell Provider (for Text reminders):______________________

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 Vitamin D3? ☐ No ☐ Yes

Do you take Probiotics? ☐ No ☐ Yes

Do you take Enzymes? ☐ No ☐ Yes

Do you take Synthetic/Man-Made Vitamins? ☐ 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	☐	☐	Digestion	☐	☐	Cancer	☐	☐
Dizziness	☐	☐	Asthma	☐	☐	Heart Disease	☐	☐
Jaw Pain (TMJ)	☐	☐	Allergies	☐	☐	Stroke/TIA	☐	☐
Neck Pain	☐	☐	Sinus	☐	☐	Osteoporosis	☐	☐
Arm/Hand Pain	☐	☐	Arthritis	☐	☐	Psychiatric Problems	☐	☐
Arm/Hand Numbness	☐	☐	Alcohol/Drug Abuse	☐	☐			
Shoulder Pain	☐	☐	HIV/AIDS	☐	☐			
Upper Back Pain	☐	☐	Kidney Problems	☐	☐			
Mid Back Pain	☐	☐	Diabetes	☐	☐			
Low Back Pain	☐	☐	Hepatitis	☐	☐			
Leg/Foot Pain	☐	☐	Infectious Disease	☐	☐			
Leg/Foot Numbness	☐	☐	Thyroid	☐	☐			

WOMEN ONLY

Are you pregnant?	☐ No	☐ Yes
Do you take oral birth control?	☐ No	☐ Yes
Are you nursing?	☐ No	☐ Yes
Do you have breast implants?	☐ No	☐ Yes
Do you have painful periods?	☐ No	☐ Yes
Do you have irregular cycles?	☐ No	☐ Yes

SURGERIES

Spinal ☐ Sinus ☐ Tonsils ☐ Throat ☐ Thyroid ☐ Colon ☐ Stomach ☐

Appendix ☐ Gallbladder ☐ Hysterectomy ☐ Other ______________________________

PERTINENT INFORMATION NOT LISTED ELSEWHERE

Please use this space to share any additional information about your health history & status, previous treatments, goals for care, etc., that you feel that Dr. Clark should be aware of:

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.)