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: _____ Spouse's 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 _____

renaissance
CHIROPRACTIC, P.C.

Dr. Khaled Elganainy & Dr. Mazin Abdelmalek

CURRENT HEALTH CONDITION

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

_____

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ❑ **Yes** ❑ **No. When?** _____

Is the Condition: ❑ **Auto Related** ❑ **Job Related** ❑ **Home Injury**

❑ **Slip or Fall** ❑ **Lifting** ❑ **Slept Wrong** ❑ **Unknown Cause** ❑ **Other**

Explain: _____

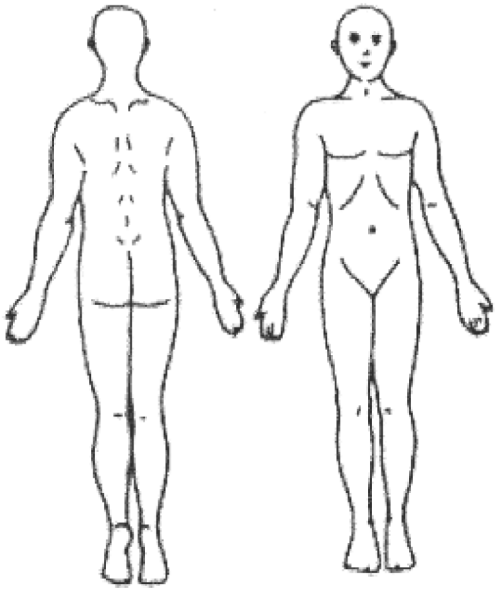
_____

Date of Accident: _____ **Time of Accident**: _____ **am /pm**

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us? _____

PLEASE LABEL on the diagram the area of discomfort.
Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.
Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



REVIEW OF SYSTEMS

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

CONSTITUTIONAL: ❑ **I DENY having or have had any of the symptoms or problems listed below.**

❑ **chills** ❑ **fatigue** ❑ **night sweats** ❑ **weight loss**

❑ **daytime drowsiness** ❑ **fever** ❑ **weight gain**

EYES/VISION: ❑ **I DENY having any of the symptoms or problems listed below.**

❑ **blindness** ❑ **change in vision** ❑ **field cuts** ❑ **photophobia**

❑ **blurred vision** ❑ **double vision** ❑ **glaucoma** ❑ **tearing**

❑ **cataracts** ❑ **eye pain** ❑ **itching** ❑ **wear glasses/contacts**

EARS, NOSE AND THROAT: ❑ **I DENY having any of the symptoms or problems listed below.**

❑ **bleeding** ❑ **ear drainage** ❑ **hearing loss** ❑ **nosebleeds** ❑ **sore throat**

❑ **dentures** ❑ **ear pain** ❑ **history of head injury** ❑ **postnasal drip** ❑ **tinnitus (ringing in ears)**

❑ **difficulty swallowing** ❑ **fainting** ❑ **hoarseness** ❑ **rhinorrhea (runny nose)**

❑ **discharge** ❑ **frequent sore throats** ❑ **loss of sense of smell** ❑ **sinus infections** ❑ **TMJ problems**

❑ **dizziness** ❑ **headaches** ❑ **nasal congestion** ❑ **snoring**

RESPIRATION: ❑ **I DENY having any of the symptoms or problems listed below.**

❑ **asthma** ❑ **coughing up blood** ❑ **sputum production**

❑ **cough** ❑ **shortness of breath** ❑ **wheezinG**

CARDIOVASCULAR: ❑ **I DENY having any of the symptoms or problems listed below.**

❑ **angina (chest pain or discomfort)** ❑ **high blood pressure** ❑ **shortness of breath with exertion or exercise**

❑ **chest pain** ❑ **low blood pressure** ❑ **swelling of legs**

❑ **claudication (leg pain/ache)** ❑ **orthopnea (difficulty breathing lying down)** ❑ **ulcers**

❑ **heart murmur** ❑ **palpitations** ❑ **varicose veins**

❑ **heart problems** ❑ **paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)**

GASTROINTESTINAL: ❑ I DENY having any of the symptoms or problems listed below.

❑ abdominal pain ❑ diarrhea ❑ indigestion ❑ abnormal stool caliber ❑ vomiting blood
❑ belching ❑ difficulty swallowing ❑ jaundice ❑ abnormal stool color
❑ black - tarry stools ❑ heartburn ❑ nausea ❑ abnormal stool consistency
❑ constipation ❑ hemorrhoids ❑ rectal bleeding ❑ vomiting

FEMALE: ❑ I DENY having any of the symptoms/problems and/or using any of the items listed below.

❑ birth control ❑ cramps ❑ irregular menstruation ❑ vaginal bleeding
❑ breast lumps/pain ❑ frequent urination ❑ pregnancy ❑ vaginal discharge
❑ burning urination ❑ hormone therapy ❑ urine retention

MALE: ❑ I DENY having any of the symptoms or problems listed below.

❑ burning urination ❑ frequent urination ❑ prostate problems
❑ erectile dysfunction ❑ hesitancy/dribbling ❑ urine retention

ENDOCRINE: ❑ I DENY having any of the symptoms or problems listed below.

❑ cold intolerance ❑ excessive hunger ❑ goiter ❑ unusual hair growth
❑ diabetes ❑ excessive thirst ❑ hair loss ❑ voice changes
❑ excessive appetite ❑ abnormal frequency of urination ❑ heat intolerance

SKIN: ❑ I DENY having any of the symptoms or problems listed below.

❑ changes in nail texture ❑ hair loss ❑ itching ❑ skin lesions / ulcers
❑ changes in skin color ❑ hives ❑ paresthesias ❑ varicosities
❑ hair growth ❑ history of skin disorders ❑ rash

NERVOUS SYSTEM: ❑ I DENY having any of the symptoms or problems listed below.

❑ dizziness limb weakness ❑ numbness ❑ slurred speech ❑ tremor
❑ facial weakness ❑ loss of consciousness ❑ seizures ❑ stress ❑ unsteadiness of gait/loss of bala
❑ headache ❑ loss of memory ❑ sleep disturbance ❑ strokes

PSYCHOLOGIC: ❑ I DENY having any of the symptoms or problems listed below.

❑ anhedonia ❑ behavioral change ❑ convulsions ❑ memory loss
❑ anxiety ❑ bi-polar disorder ❑ depression ❑ mood change
❑ loss or change in appetite ❑ confusion ❑ insomnia

ALLERGY: ❑ I DENY having any of the symptoms or problems listed below.

❑ anaphalaxis ❑ itching ❑ chronic nasal congestion ÿ sneezing
❑ food intolerance ❑ acute nasal congestion ❑ rash

HEMATOLOGIC: ❑ I DENY having any of the symptoms or problems listed below.

❑ anemia ❑ blood clotting ❑ bruising easily ❑ lymph node swelling
❑ bleeding ❑ blood transfusion ❑ fatigue

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

PREVIOUS CARE FOR SAME CONDITION ❑ I have not seen a doctor for this condition OR Fill in the information below

Have you seen other doctors for THIS CONDITION? ❑ Yes ❑ No **If yes, Who? (Name)** _____

Type of Treatment: _____ **Was the treatment beneficial in resolving condition?** ❑ Yes ❑ No

Explain: _____

PREVIOUS CHIROPRACTIC CARE: ❑ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ **Location:** _____ **Date of Last Visit:** _____

CURRENT MEDICATION *(s)*: List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

CHILDHOOD ILLNESS(ES): LIST ALL HEALTH CONDITIONS. CIRCLE ALL CURRENT CONDITIONS.

❑ ADD	❑ chicken pox	❑ headaches	❑ scoliosis
❑ atopic dermatitis (eczema)	❑ crohn's/colitis	❑ hepatitis	❑ seizure disorder
❑ allergies/hayfever	❑ depression	❑ HIV	❑ sickle cell anemia
❑ anemia	❑ diabetes	❑ measles	❑ spina bifida
❑ asthma	❑ ear infections	❑ mumps	❑ other:
❑ bedwetting	❑ fetal drug exposure	❑ psoriasis	
❑ cerebral palsy	❑ food allergies (list below)	❑ rash	

ADULT ILLNESS(ES): LIST ALL HEALTH CONDITIONS. CIRCLE ALL CURRENT CONDITIONS.

❑ ADD	❑ cystic kidney disease	❑ hypertension	❑ psychiatric problems
❑ alzheimers	❑ depression	❑ influenzal pneumonia	❑ scoliosis
❑ anemia	❑ diabetes (insulin dep)	❑ liver disease	❑ seizures
❑ arthritis	❑ diabetes (non insulin)	❑ lung disease	❑ shingles
❑ asthma	❑ eczema	❑ lupus erythema (discoid)	❑ past history of similar symptoms
❑ cancer	❑ emphysema	❑ lupus erythema (systemic)	❑ STD's (unspecified)
❑ cerebral palsy	❑ eye problems	❑ multiple sclerosis	❑ suicide attempt(s)
❑ chicken pox	❑ fibromyalgia	❑ parkinson's disease	❑ thyroid problems
❑ crohn's/colitis	❑ heart disease	❑ unspecified pleural effusion	❑ vertigo
❑ CRPS (RSD)	❑ hepatitis	❑ pneumonia	❑ other:
❑ CVA (stroke)	❑ HIV	❑ psoriasis	

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ❑ yes or ❑ no.

SURGER (IES): LIST ALL SURGICAL PROCEDURES. WRITE THE DATE OF THE PROCEDURE IMMEDIATELY AF

❑ angioplasty	❑ cosmetic	❑ hysterectomy	❑ pacemaker insertion
❑ appendectomy	❑ D & C	❑ joint reconstruction	❑ rotator cuff
❑ caesarian section	❑ dental surgery	❑ joint replacement	❑ spinal fusion
❑ cardiac catheterization	❑ gall bladder	❑ knee repair	❑ tonsilectomy
❑ carpal tunnel repair	❑ hemorrhoidectomy	❑ laminectomy	❑ other:
❑ coronary artery bypass	❑ hernia repair	❑ mastectomy	

INJURY(IES): MARK OR LIST ALL INJURIES. WRITE THE DATE OF THE INJURY IMMEDIATELY AFTERWARD.

❑ back injury	❑ head injury (loss of consciousness)	❑ motor vehicle accident
❑ broken bones	❑ head injury (no loss of consciousness)	❑ soft tissue injury (mild)
❑ disability (ies)	❑ industrial accident	❑ soft tissue injury (moderate)
❑ fall (severe)	❑ joint injury	❑ soft tissue injury (severe)
❑ fracture	❑ laceration (severe)	❑ other:

FAMILY HISTORY: Mark all that apply below. List any specific conditions past or present after has/had:

general family ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

father ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

mother ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

paternal grandfather ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

paternal grandmother ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

maternal grandfather ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

maternal grandmother ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

son (s) ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

daughter(s) ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

brother(s) ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

sister(s) ❑ alive ❑ deceased ❑ normally developed ❑ no significant disease ❑ has/had:_____

SOCIAL HISTORY

Alcohol: ❑ Never ❑ Social Consumption only ❑ Beer ❑ Liquor ❑Wine; _____ oz ____ glasses; ❑ Day ❑ Week ❑ Month

Diet (please mark all that apply): ❑ High Fat ❑ High Fiber ❑ High Protein ❑ High Salt ❑ Low Calorie ❑ Low Carb ❑ Low Fiber ❑ Low Salt ❑ Low Sugar

Education (please mark the highest level completed): ❑ Preschool ❑ Elementary ❑ Middle ❑ Jr High ❑ Votech ❑ In High School ❑ Did Not Finish High School ❑ High School Diploma ❑ Post High School Classes ❑ Assoc/Technical Degree ❑ In College ❑ College Degree ❑ In Graduate School ❑ Graduate Degree ❑ Doctorate ❑ Other: _____

Drugs: ❑ Deny any illegal drug use ❑ Deny use of IV drugs ❑ Have not used drugs since _____ ❑ Have used drugs for _____

Tobacco: ❑ Deny Tobacco Use ❑ Do not smoke cigars, cigarettes or pipe ❑ Live with a smoker ❑ Quit smoking ❑ Smoke; # _____ per ❑ Day ❑ Week ❑ Month ❑ Chew; #_____cans per ❑ Day ❑ Week ❑ Year

INSURANCE INFORMATION:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) ❑ Myself ONLY

❑ Spouse ❑ Worker's Comp ❑ Auto Insurance ❑ Medicare ❑ Medicaid ❑ Other (be specific):_____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____-_____-_____ Primary Care Physician: _____

WORKERS COMPENSATION INJURY/AUTO/PERSONAL INJURY:

Have you filed an injury report with your employer? ❑ Yes ❑ No Date:___/___/_____Time: _____am/pm

Carrier: _____ Policy # _____

Carriers Phone #: (_____) _____-_____ Adjuster: _____

Claim #: _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: _____

Patient's Signature: _____ Date: _____

EMPLOYMENT, ADL, AND RECREATION INFORMATION

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

Occupation/Job Title: _____ **Work:** _____ **hrs / day or week**

Description of Work: _____

Job Classification: ❑ **Sedentary** (<5lbs) ❑ **Light** (5-20lbs) ❑ **Moderate** (20-50lbs) ❑ **Heavy** (>50 lbs)

Lifting Frequency: ❑ **Constant** (67-100%/day) ❑ **Frequent** (33-66%/day) ❑ **Occasional** (0-32%/day)

Lifting Postures: ❑ **with Arms** ❑ **High Near** ❑ **from Knee** ❑ **Off Posture** ❑ **from Torso**

Work Activity Postures: (hrs/day)

❑ **bending:** _____h/d ❑ **climbing:** _____h/d ❑ **kneeling:** _____h/d ❑ **pulling:** _____h/d ❑ **pushing:** _____h/d

❑ **reaching:** _____h/d ❑ **sitting:** _____h/d ❑ **standing:** _____h/d ❑ **twisting:** _____h/d ❑ **walking:** _____h/d

Repetitive Activities: (hrs/day)

❑ **assembly/fine manipulation:** _____h/d ❑ **computer use/typing:** _____ h/d ❑ **grasping:** _____ h/d

❑ **hand tool use:** _____ h/d ❑ **operation of machinery controls:** _____ h/d ❑ **phone use:** _____h/d

Condition's Effect On Job Performance: ❑ **No Effect** ❑ **Mild** Painful (Can do) ❑ **Mod** Painful (limited ability)

❑ **Mod/Sev** Limited Duty ❑ **Sev** No Limited Duty ❑ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Care –Infirm Family:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Carrying Groceries:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Change Posn–Sit-Stand:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Climb Stairs:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Driving:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Extended Computer Use:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Feeding:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Household Chores:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Kneeling:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Lift Children:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Lifting:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Pet Care:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Reading (Concentration):	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Self Care–Bathing:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Self Care–Dressing:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Self Care–Shaving:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Sexual Activities:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Sleep:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Static Sitting:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Static Standing:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Walking:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
Yard Work:	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	❑ No Effect	❑ Mild **Painful (Can do)**	❑ Mod **Painful (Limited)**	❑ Sev **Unable to Perform**
_____	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform
_____	❑ **No Effect**	❑ **Mild** Painful (Can do)	❑ **Mod** Painful (Limited)	❑ **Sev** Unable to Perform

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Further, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered by me are charged to me and I am personally responsible for payment. I also understand that I suspend or terminated my care or treatment; any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Chiropractic Clinic to treat my condition as he or she deems appropriate through the use of Chiropractic, and I give authority for these procedures to be performed. If is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name:_____

Patient Signatures:_____

Date:_____

Consent to treat a Minor:_____

Date:_____

Guardian or Spouse's Signature of Authorizing Care:_____

Date:_____

X-RAY QUESTIONNAIRE FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:_____

- ❑ There is a possibility that I MAY BE PREGNANT AT THIS TIME
- ❑ Yes, I am definitely pregnant
- ❑ No, I am not pregnant at this time.

❑ I request that x-ray films not be taken because _____

Signature_____

Date_____

ONE TIME AUTHORIZATION AGREEMENT (FOR MEDICARE PATIENTS ONLY)

I, ___ Medicare Number ___ request that payment of authorized Medicare benefits be made either to me or on my behalf to Renaissance Chiropractic for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary signature:_____

Date:_____

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge that I have received the Chiropractic Clinic's Notice of Pricy Practices for protected health information, and my understanding and my agreement to his terms.

Patient First Name:_____Date:_____

Patient Signature:_____ Date: _____

CONSENT TO RELEASE INFORMATION

I would like my information sent to my ❑ M.D. ❑ D.O. ❑ D.D.S. ❑ Podiatrist ❑ Other _____

Patient First Name:_____Date:_____