



**Confidential Patient Health Record**

**Today's Date:** \_\_\_/\_\_\_/\_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  Dr. \_\_\_\_\_

**Personal Information**

Title:  Mr.  Ms.  Mrs.  Dr.  Rev.  Miss  Prof.  other: \_\_\_\_\_  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Suffix:  Jr  Sr  II  III  MD  PhD  DO  Esq  PA  RN  BSN  other: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_  
Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_  
Children (Names and Ages): \_\_\_\_\_

**Emergency Contact**

Title:  Miss  Mrs.  Ms.  Master  Mr.  Dr.  Prof.  Rev.  other: \_\_\_\_\_  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Employment Information**

Business Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation/Job Title: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

**Current Health Condition: Chief Complaint – History of Present Illness**

Why you are here today? \_\_\_\_\_

**PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT**

**Body Area(s) Involved:**       Neck     Back

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

When did this Condition BEGIN? \_\_\_\_/\_\_\_\_/\_\_\_\_

**Key: A=Ache B=Burning N = Numbness**

Has it ever occurred before?  Yes     No    When? \_\_\_\_\_

**P=Pins & Needles S=Stabbing**

**Mechanism of Onset:**

- Auto:**                       Driver/Passenger     Pedestrian                      (please complete auto accident history form)  
 **Work Related:**       Fall     Falling Object     Lifting     Overexertion     Repetitive Motion     Other: \_\_\_\_\_

**Have you filed an injury report with your employer?**     Yes     No      **Please Notify the Front Desk Now if “Yes”**

**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       Localized       Dull/Aching     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 episode: \_\_\_\_\_      Worsened: \_\_\_\_\_

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

**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       Stiffness       Ringing in Ears  
 Sleep Disturbance

**Headaches:**      **Location:**       Occipital       Frontal       Left Temporal       Right Temporal  
 Parietal       Sinus

**Quality:**       Dull       Sharp       Throbbing       Stabbing       Aura

**Types:**       Hat Band       Cluster       Migraine       Tension

**Other:**      (frequency/duration/time of day) \_\_\_\_\_

**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

**Modifying Factors:**

- Symptoms Better With:  nothing helps  activity  bending  rest  
 stretching  sitting  standing  twisting  walking  
 applying cold  applying heat  massage  movement  
 Over the counter medication  Prescription medication

Since condition began, has anything permanently helped you?  YES  NO

Has anything that you have done, thus far, fixed you problem?  YES  NO

**Employment:**

Occupation/Job Title: \_\_\_\_\_ Work: \_\_\_\_\_ hrs /day

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)  hand tool use: \_\_\_\_\_ h/d  assembly/fine manipulation: \_\_\_\_\_h/d

grasping: \_\_\_\_\_ h/d  operation of machinery controls: \_\_\_\_\_ h/d

phone use: \_\_\_\_\_h/d  computer use/typing: \_\_\_\_\_ h/d

**Condition’s Effect On Job Performance:**

- No Effect  Mild Painful (Can do)  Mod Painful (limited ability)  Sev Painful (Unable to Perform)

**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)

Exercise:  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:  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)

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)

**Review of Systems****Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- |   |   |                                     |  |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness      | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia           |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision    | <input type="checkbox"/> glaucoma   | <input type="checkbox"/> tearing               |
| <input type="checkbox"/> cataracts      | <input type="checkbox"/> eye pain         | <input type="checkbox"/> itching    | <input type="checkbox"/> wear glasses/contacts |

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- |                                    |  |   |   |   |
|------------------------------------|--|---|---|---|
| <input type="checkbox"/> dentures  | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections | <input type="checkbox"/> history of head injury     |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> headaches             | <input type="checkbox"/> nasal congestion       | <input type="checkbox"/> sore throat      | <input type="checkbox"/> tinnitus (ringing in ears) |
| <input type="checkbox"/> ear pain  | <input type="checkbox"/> hearing loss          | <input type="checkbox"/> nosebleeds             | <input type="checkbox"/> snoring          | <input type="checkbox"/> rhinorrhea (runny nose)    |
| <input type="checkbox"/> fainting  | <input type="checkbox"/> hoarseness            | <input type="checkbox"/> postnasal drip         | <input type="checkbox"/> TMJ problems     | <input type="checkbox"/> difficulty swallowing      |

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

- |                                 |                                |  |                                   |
|---------------------------------|--------------------------------|--|-----------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing |
|---------------------------------|--------------------------------|--|-----------------------------------|

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> varicose veins  | <input type="checkbox"/> ulcers              |
| <input type="checkbox"/> palpitations                      | <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> chest pain                        | <input type="checkbox"/> swelling of legs  |  |
| <input type="checkbox"/> claudication (leg pain/ache)      | <input type="checkbox"/> orthopnea (difficulty breathing lying down)                           |  |
| <input type="checkbox"/> heart murmur                      | <input type="checkbox"/> shortness of breath with exertion or exercise                         |  |
| <input type="checkbox"/> heart problems                    | <input type="checkbox"/> paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath) |  |

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

- |   |  |                                      |                                   |
|---|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea              | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> nausea   |
| <input type="checkbox"/> belching       | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> indigestion | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> constipation   | <input type="checkbox"/> heartburn             | <input type="checkbox"/> jaundice    |                                   |

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> birth control     | <input type="checkbox"/> cramps             | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> hormone therapy |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> frequent urination | <input type="checkbox"/> pregnancy              | <input type="checkbox"/> urine retention |

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> burning urination    | <input type="checkbox"/> frequent urination   | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/ dribbling | <input type="checkbox"/> urine retention   |

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> cold/heat intolerance | <input type="checkbox"/> excessive hunger/thirst | <input type="checkbox"/> goiter                          | <input type="checkbox"/> unusual hair growth/loss |
| <input type="checkbox"/> diabetes              | <input type="checkbox"/> excessive appetite      | <input type="checkbox"/> abnormal frequency of urination |   |

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

- |  |                                      |                                  |                                       |
|--|--------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair growth | <input type="checkbox"/> hives   | <input type="checkbox"/> paresthesias |
| <input type="checkbox"/> changes in skin color   | <input type="checkbox"/> hair loss   | <input type="checkbox"/> itching | <input type="checkbox"/> rash         |

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- |  |  |   |  |                                 |
|--|--|---|--|---------------------------------|
| <input type="checkbox"/> dizziness       | <input type="checkbox"/> limb weakness         | <input type="checkbox"/> numbness       | <input type="checkbox"/> slurred speech                        | <input type="checkbox"/> tremor |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> seizures       | <input type="checkbox"/> stress                                | <input type="checkbox"/> stroke |
| <input type="checkbox"/> headache        | <input type="checkbox"/> sleep disturbance     | <input type="checkbox"/> loss of memory | <input type="checkbox"/> unsteadiness of gait/ loss of balance |                                 |

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

- |   |  |                                      |                                      |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> anhedonia                  | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> anxiety                    | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression  | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> confusion         | <input type="checkbox"/> insomnia    |                                      |

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

- |                                   |  |  |  |
|-----------------------------------|--|--|--|
| <input type="checkbox"/> anemia   | <input type="checkbox"/> blood clotting    | <input type="checkbox"/> bruising easily | <input type="checkbox"/> lymph node swelling |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> fatigue         |  |

**Past Health History – Fill out carefully as the information provided can affect your overall course of care.**

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Were you satisfied with the results of your treatment?  Yes  No

Explain: \_\_\_\_\_

**Previous Chiropractic Care:  I have not previously seen a Chiropractor.**

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Were you satisfied with your care?  Yes  No. Why? \_\_\_\_\_

Do you wear any of the following?  Heel Lifts  Innersoles  Arch Supports  Orthotics  Other \_\_\_\_\_

For how long? \_\_\_\_\_ Were they prescribed by a doctor?  Yes or  No

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

Medication	Dosage	For What Condition?	Taking for How Long?

**Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.**

Type	Dosage	For What Condition, if any?	Taking for How Long?

**Childhood Illness (es): LIST all health conditions. SELECT all CURRENT conditions.**

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

**Adult Illness (es): SELECT all CURRENT health conditions.**

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

**Females ONLY: Ob/Gyn Mark all that apply below.**

- |  |  |
|--|--|
| I... <input type="checkbox"/> am currently pregnant  | <input type="checkbox"/> am NOT currently pregnant     |
| I... <input type="checkbox"/> currently have menses. | <input type="checkbox"/> currently DO NOT have menses. |
| My menses... <input type="checkbox"/> are regular.   | <input type="checkbox"/> are NOT regular.              |

**Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

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

**Non-Drug Allergies: Mark all that apply below.**

- animals
- bee sting
- chocolate
- dairy
- eggs
- latex
- mold
- nuts
- perfumes
- pollen
- shellfish
- soap
- soy
- wheat
- other:

**Family History: Mark all that apply below. List any specific conditions past or present after has/had:**

- |                |                                |                                   |   |   |   |
|----------------|--------------------------------|-----------------------------------|---|---|---|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father         | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother         | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s)        | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s)    | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s)     | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s)      | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

**Social History: Mark all that apply below.**

Alcohol:  do not drink alcohol  social consumption only  drink regularly

My Dietary Intake consists mainly of the following: (mark all that apply)

- high fat
- high fiber
- high protein
- high salt
- low calorie
- low carbohydrate
- low fiber
- low salt
- low sugar

Tobacco:  Do not use tobacco  Live with a smoker  Quit smoking  Smoke: # \_\_\_\_ per  Day  Week

**\*\*\* Notice of Privacy Rights:**

I have received and read a copy of this office's Notice of Privacy Practices.

Patient Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Treat a Minor**

I \_\_\_\_\_ being the parent or guardian of \_\_\_\_\_, a minor, the age of \_\_\_\_\_ do hereby consent, authorize and request Dr. Guy Margolin to administer such treatment deemed advisable, necessary and requested on the above minor. I agree to hold him free and harmless from any claims, suits for damages or complications which may result from such treatment.

\_\_\_\_\_  
Guardian Print Name

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date