MARKET PLACE CHIROPRACTIC WELLNESS CENTER
PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name: First______________Initial____Last________________

Address:_________________________________

City:____________________State:____Zip:________

Date of Birth:______________Age:______Gender ☐ M ☐ F

Home Phone:_______________________________

Cell Phone:________________________________

Cell Provider (for Text reminders):______________

E-Mail Address:____________________________

Work Phone:_______________Occupation:__________

Employer:__________________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced

☐ Separated ☐ Widowed

ABOUT THE SPOUSE OR PARENT

Name:_____________________________________

Cell Phone:_________________________________

Insurance Holder Date of Birth:___________________

REFERRAL SOURCE

How did you hear about our office?

☐ Internet (site)_____________________________

☐ Patient referral (name)_______________________

☐ Other referral source_________________________

EXPERIENCE WITH CHIROPRACTIC

Have you had chiropractic care before? ☐ No ☐ Yes

Reason for those visits:__________________________

Previous Chiropractor's Name:____________________

Approximate Date of Last Adjustment:______________

EXPERIENCE WITH MASSAGE

Have you had a massage before? ☐ No ☐ Yes

Reason for those visits:__________________________

____

Previous LMP Name:_______________________________

Approximate Date of Last Massage:__________________

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 and/or Licensed Massage Therapists should be aware of:

AUTHORIZATION FOR CHIROPRACTIC CARE and/or MASSAGE THERAPY

I hereby authorize Market Place Chiropractic Wellness Center, PLLC, Dr. Jeffrey P. Clark, or whomever he may authorize as a Doctor of Chiropractic or a Licensed Massage Therapist to work with my condition through the use of chiropractic adjustments, massage therapy 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 treatment records, including 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.)