Dr. Gregory S. Malakoff, Chiropractor

Confidential Patient Health Record Date_____

PERSONAL HISTORY

Name: _____
Address: _____
City: _____ State: _____ ZIP _____
Home Phone: _____ Cell Phone _____
Work Phone _____ Birth Date: _____ Age: _____
Email: _____
Sex: □ M □ F Circle One: Married Single Widowed Divorced Separated
Business/Employer: _____ Type of Work: _____
Name of Spouse _____ Referred To this Office By: _____
Name and Number of Emergency Contact: _____
Relationship: _____

CURRENT HEALTH CONDITION

What is your chief complaint? _____
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: _____ Time of Accident: _____
If injured at work 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
□ Others _____

Do You Suffer From Any Condition Other Than Your Chief Complaint?

_____

_____

_____

PAST HEALTH HISTORY

Please Describe:

Major Surgery/Operations/Accidents: Include approximate dates if possible.

_____

_____

_____

Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit

_____

Below are lists of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

□ Pneumonia □ Mumps □ Influenza □ Rheumatic Fever □ Small Pox
□ Chicken Pox □ Arthritis □ Polio □ Diabetes □ Epilepsy □ Whooping Cough
□ Anemia □ Cancer □ Thyroid □ Heart □ Measles □ Mental Disorders
□ Lumbago □ Eczema □ HIV □ Shingles □ Mono □ Chronic Fatigue
□ Pleurisy □ Tuberculosis

Fill-in Daily Consumption: Coffee _____Tea _____ Alcohol _____
Cigarettes _____ White Sugar _____

CHECK ANY YOU HAVE HAD IN THE LAST 6 MONTHS:

MUSCULO-SKELETAL SYSTEM

□Low Back Pain □ Neck Pain □ Arm Pain
□ Joint Pain/Stiffness □ Pain Between Shoulders □ Walking Problems
□ General Stiffness □ Difficult □Chewing/Clicking Jaw

NERVOUS SYSTEM

□ Nervous □ Numbness □ Paralysis □ Dizziness □ Stress
□ Confusion/Depression □ Fainting □ Convulsions
□Cold/Tingling Extremities □ Forgetfulness

GENERAL

□ Fatigue □ Allergies □ Headaches □ Fever □ Loss of Sleep

GASTRO-INTESTINAL SYSTEM

□ Poor Appetite □ Excessive Hunger □ Excessive Thirst □ Frequent Nausea □ Vomiting
□ Diarrhea
□ Constipation □ Hemorrhoids □ Liver Trouble
□ Gall Bladder Problems □ Colitis □ Weight Trouble
□ Gas/Bloating After Meals □ Heartburn □ Black/Bloody Stool

GENITO-URINARY SYSTEM

□ Bladder Trouble □ Painful/Excessive Urination
□ Discolored Urine □ Prostatitis

CARDIO VASCULAR SYSTEM

□ Chest Pain □ Short Breath □ Ankle Swelling
□ Blood Pressure Problems □ Irregular Heartbeat □ Heart Problems
□ Lung Problems/Congestion □ Varicose Veins □ Stroke

EARS, EYES, NOSE, THROAT

□ Vision Problems □ Dental Problems □ Sore Throat
□ Ear Aches □ Hearing Difficulty □ Stuffed Nose
□ Sinus Trouble

FEMALE REPRODUCTIVE SYSTEMS

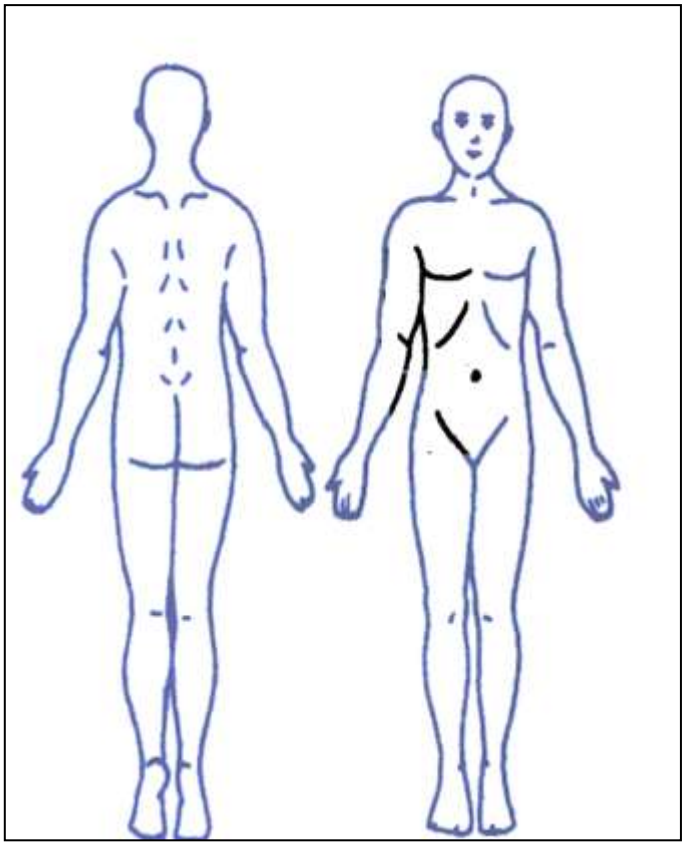
□ Menstrual Irregularity □ Menstrual Cramps □ Vaginal Pain/Infection
□ Breast Pain □ Lumps □ Cysts
When was your last period?_____Are you Pregnant? □ Yes □ No □ Not Sure

MALE REPRODUCTIVE SYSTEM

□ Prostate Problems □ Sexual Dysfunction □ Other Problems_____

FAMILY HISTORY

The following members have a same or similar problem as I do:
□ Mother □ Father □ Brother □ Sister □ Spouse □ Child □ None



Please outline on the diagram the area of your discomfort. Put a number value in the appropriate areas. For example from 1-10, 10 being the worse pain you could experience. You would use a 10 to describe a pain that would require hospitalization.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at time of service and that this creates the ability for the doctor to pass savings on as reflected by reduced fees as compared to the usual and customary fees for these similar services. I acknowledge that Dr. Malakoff has explained-disclosed the benefits and risks associated with chiropractic treatment and understand that my confidential medical records will be treated in accordance to the standards and practices of the HIPPA codes. I hereby authorize Dr. Malakoff to treat my condition, as he deems appropriate.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____