



Confidential Patient Health Record

First Name: _____ Middle Initial: _____ Last Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Sex: Male Female # of Children _____ Circle One: Married Single Widowed Divorced

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Occupation: _____

How were you referred to our office? _____

In case of emergency, please contact (included phone # and relationship): _____

Please describe your condition (s) beginning with the most severe:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

When did this/these conditions begin? _____

What makes the condition better? _____

What makes the condition worse? _____

Have you seen any other physician for this condition? (Please list name and dates) _____

Have you ever had symptoms similar to your present condition? _____

Please list your family physician, including location (city and state): _____

List any medications you are currently taking: _____

Please list your complete surgical history (give dates and types of surgery) _____

Have you ever been involved in an automobile accident? (If yes, please give dates & explain the accident): _____

Please list any other health concerns (i.e.. diabetes, high blood pressure): _____

Have you received treatment for these concerns? Yes No

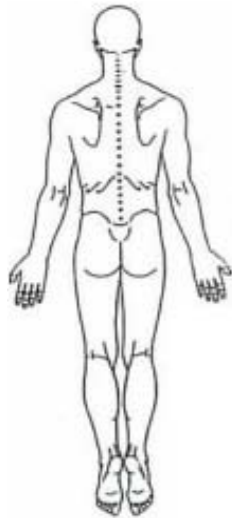
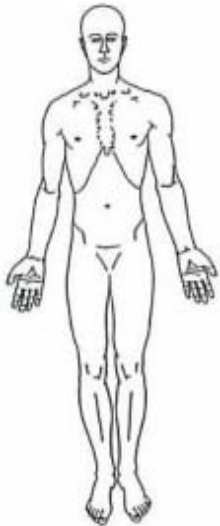
If so, indicate where, when, and the name of the treating doctor: _____

If you are experiencing any of the following conditions, please indicate on the diagram below.

A=ACHE B=BURNING N=NUMBNESS

P=PAIN S=STABBING O=OTHER

Please Check The Spaces Below For Symptoms You are Currently Having.



- | | |
|------------------------|-------------------------|
| ___ Headaches | ___ Dizziness |
| ___ Neck Pain | ___ Neck Stiffness |
| ___ Upper Back Pain | ___ Shoulder Pain |
| ___ Arm/Hand Pain | ___ Numbness/Tingling |
| ___ Mid Back Pain | ___ Low Back Pain |
| ___ Hip/Buttock Pain | ___ Leg/Foot Pain |
| ___ Ear Noises | ___ Sinus Infection |
| ___ Vision Problems | ___ Allergies |
| ___ Chest Pain | ___ Difficult Breathing |
| ___ Frequent Urination | ___ Prostate Problems |
| ___ Arthritis | ___ Bursitis |
| ___ Stroke | ___ Asthma |

Name of Person responsible for payment (if different from patient): _____

Name of Insurance Company: _____

Name of the Insured (if not you): _____ Date of Birth of Insured: _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I hereby authorize Dr. Ju to examine me, including x-rays if indicated by my exam, and to release my record to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny paying or make payment directly to me.

By signing your name below, you certify the accuracy of your medical and/or accident history and further certify that you present to Dr. Ju and his staff members at Ju Chiropractic Wellness Center for evaluation and treatment of a health related condition and for no other purpose.

Signature of Patient, Guardian Authorizing Care

Date of Signing