Kare Chiropractic – Dr. Carl Makarewicz
3899 Mid Rivers Mall Dr., St. Peters, MO 63376

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. Suffix: □ Jr □ Sr □ II □ III

Last:_____ First:_____ Middle: _____

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: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact

Last:_____ First:___ _____ Relationship: □ Spouse □ Relative □ Friend □ Other Home

Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employment Information

Business Name: _____

Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Employer's Email Address: _____

Occupation/Job Title: _____ Job Description _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information. I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand this Chiropractic Office will prepare any necessary reports & forms to assist me in making collection from the insurance company & that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand & agree that all services rendered to me are charges directly to ma & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

I hereby authorize & release the doctor & whom ever he may designate as his assistant to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; and further authorize him to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including, but not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient Name: _____

Patient Signature: _____ Date: _____

Chief Complaint – HPI (History of Present Illness)

Body Area(s) Involved: □ Cervical □ Spine, Ribs, Pelvis □ Upper Extremity □ Lower Extremity

Condition: □ New → □ Acute or □ Chronic

□ Recurrence (Acute) □ Exacerbation (Acute) □ Chronic

Mechanism of Onset:

□ Auto: □ Driver/Passenger □ Pedestrian (refer to completed auto accident history form)
□ Work Related: □ Fall □ Falling Object □ Lifting □ Overexertion □ Repetitive Motion □ Other: _____
□ 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 □ Dull/Aching □ Localized □ 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 Occurred:_____ Last episode:_____ Resolved Previous Visit:_____
Worsened:_____ Injury Occurred:_____ Accident Occurred:_____

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

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 □ Ringing in Ears □ Sleep Disturbance □ Stiffness

Headaches: Location: □ Occipital □ Frontal □ Left Temporal □ Right Temporal □ Parietal □ Sinus
Quality: □ Dull □ Sharp □ Throbbing □ Stabbing □ Aura □ No Aura
Types: □ Hat Band □ Cluster □ Migraine □ Tension Other: (frequency/duration/time of day_____

Radiation: Left / Right / Bilateral _____

Weakness: Left / Right / Bilateral _____

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 □ applying cold □ applying heat
□ massage □ movement □ OTC meds □ Rx meds □ rest
□ stretching □ sitting □ standing □ twisting □ walking
Symptoms Worse With: (as noted in Social History)

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
Ext. 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:	□ 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
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

Employment:

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:

□ **Mild** Painful (Can do) □ **Mod** Painful (limited ability) □ **Mod/Sev** Limited Duty □ **Sev** No Limited Duty □ **Sev** (can't do limited duty)

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