WELCOME TO THE OFFICE OF

Dr. Jim Bryans

CONFIDENTIAL PATIENT HEALTH RECORD DATE: _____ I.D. #_____

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ Prov.: _____ Postal Code: _____

Home Phone:_____ Birth Date:_____ Age: _____

Sex: □ M □ F Circle One: Married Single Widowed Divorced Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____ Cell Phone #: _____

Name of Spouse: _____ Name and Ages of Children: _____

Referred to this Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

□ Personal Health Insurance (Name):_____

E-mail Address: _____

CURRENT HEALTH CONDITION

Reason for Visit: _____

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: _____

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 □ Other _____

Describe sleeping position: □ front □ back □ side

Do you suffer from any condition other than that which you are now consulting us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery

□ Broken Bones □ Other: _____

Have you ever been knocked unconscious? □ Yes □ No If yes, when _____

Major Accident or Fall: _____

_____

Hospitalization (Other Than Above): _____

_____

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

Below are a list 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 diseases you have had:

□ Pneumonia
□ Rheumatic Fever
□ Polio
□ Tuberculosis
□ Whooping Cough
□ Anemia
□ Measles
□ Mumps
□ Small Pox
□ Shingles
□ Diabetes
□ Cancer
□ Heart Disease
□ Thyroid
□ Influenza
□ Pleurisy
□ Arthritis
□ Epilepsy
□ Mental Disorders
□ Eczema
□ Lupus

INTAKE
□ Coffee
□ Tea
□ Alcohol
□ Cigarettes
□ White Sugar

Check any of the following you have had in the past 6 months:

Musculoskeletal Code
□ Low Back Pain
□ Pain between shoulders
□ Neck pain
□ Arm pain
□ Joint pain/Stiffness
□ Walking problems
□ Difficult Chewing/Clicking Jaw
□ General Stiffness

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

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

Gastrointestinal Code
□ Poor/Excessive Appetite
□ Excessive Thirst
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Weight Trouble
□ Abdominal Cramps
□ Gas/Bloating after meals
□ Heartburn
□ Black/Bloody Stool
□ Colitis

Genitourinary Code
□ Bladder Trouble
□ Painful/Excessive Urination
□ Discolored Urine

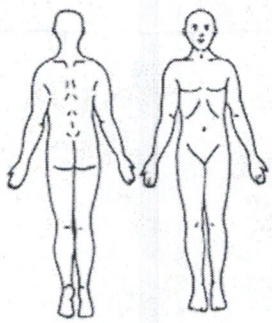
C-V-R Code
□ Chest Pain
□ Short Breath
□ Blood Pressure Problems
□ Irregular Heartbeat
□ Heart Problems
□ Lung Problems/Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke

EENT Code
□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Earaches
□ Hearing Difficulty
□ Stuffed Nose

Male/Female Code
□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/Infection
□ Breast Pain/Lumps
□ Prostate/Sexual Dysfunction
□ Other Problems
□ _____
□ _____
□ _____

Females Only:
When was your last period? _____

Are you pregnant?
□ Yes □ No □ Not sure



Please outline on the diagram the area of your discomfort.

Family History
The following members have a same or similar problem as I do:
□ Mother
□ Father
□ Brother
□ Sister
□ Spouse
□ Child