

SOUTHERN CHIROPRACTIC LIFE CENTER

Dr. David N. Migdal, D.C.
10345 Southern Boulevard
Royal Palm Beach, Florida 33411
(561) 790-6388

Confidential patient health record

Date _____

Name _____ Home Phone: _____

Street _____ Apt.# _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital Status: Single ___ Married ___ Widow(er) ___ Divorced ___ How Many Children _____

Occupation _____ Employer _____

Address _____ Office Phone: _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone: _____

Patient's Nearest Relative _____ Phone: _____

Referred by _____ If insurance claim,
name of company _____

Present family doctor _____ Address _____

Date of last physical examination _____ By Doctor _____

List present complaints:

1. _____ For how long _____

2. _____ For how long _____

3. _____ For how long _____

4. _____ For how long _____

5. _____ For how long _____

Cause of injury/illness _____

Remarks _____

List other doctors consulted for this condition(s):

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

What surgery have you had:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Remarks _____

List serious accidents and falls:

What _____ When _____

What _____ When _____

What _____ When _____

Remarks _____

List fractures:

What _____ When _____

What _____ When _____

Remarks _____

List medications and/or diet supplements you take:

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

Remarks _____

Check any of the following diseases you have or have had:

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Aids Virus | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema |

Check any of the following you have or have had repeatedly in the past five years:

General symptoms

- Headache
- Fever
- Chills
- Sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Loss of weight
- Numbness or pain in arms, hands or legs
- Allergy
- Neuralgia

Eyes, ears, nose and throat

- Failing vision
- Near sightedness
- Crossed eyes
- Eye pain
- Deafness
- Earache
- Ear noises
- Ear discharge
- Nose bleeds
- Nasal obstruction
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- Dental decay
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Nasal drainage
- Enlarged glands

Skin

- Skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Hives or allergy

Respiratory

- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Chest pain
- Difficult breathing

Cardio-vascular

- Rapid beating heart
- Slow beating heart
- High blood pressure
- Low blood pressure
- Pain over heart
- Previous heart stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Paralytic stroke

Muscle and joint

- Stiff neck
- Back ache
- Swollen joints
- Tremors
- Painful tail bone
- Foot trouble
- Pain between shoulders
- Hernia
- Spinal curvature
- Faulty posture

Genitourinary

- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection or stones
- Bed wetting
- Inability to control urine
- Prostate trouble

Gastrointestinal

- Poor appetite
- Excessive hunger
- Belching or gas
- Nausea
- Vomiting
- Vomiting of blood
- Pain over stomach
- Distention of abdomen
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids (Piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis

Female

- Painful menstrual periods
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps or back ache
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Lumps in breast
- Menopausal symptoms

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminated my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS# _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.