Honolulu Pain Relief Center

Confidential Electronic Health Record Information (EHR)

An Electronic Health Record (EHR) is an electronic version of a patient's medical history, that is maintained by the provider over time, and includes all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

Name_____ **Nickname**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Cell Phone_____ **Home Phone** _____**Work Phone**_____

Email _____ **SSN**_____

Emergency Contact_____ **Phone**_____

What is the best way to contact you? *(check one)* ❑ Home Email ❑ Work Email ❑ Cell Phone ❑ Work Phone ❑ Home Phone

Date of Birth_____ **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **# of Children**_____ **Their Ages**_____

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

PAYMENT INFORMATION

How payment will be made: ❑Cash/Check ❑Credit Card ❑Bill Insurance:

Name of Insurance Company: _____

(Please allow us to make a copy of your insurance card so we can verify your benefits)

Current medications, including dosage if known: **If there are no current medications, check here: ❑**

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ❑ Yes ❑ No

If yes, describe:_____

Have you had an X-ray or CT scan or MRI of your <u>neck or back</u> in the past 28 days? ❑ Yes ❑ No

When was the last time you were involved in an accident of any kind, please describe? _____

_____

Primary Care Physician _____ **Phone Number (_____)** _____ **-** _____

Have you ever suffered from or been diagnosed with any of the following (check all that apply)

- ❑ ***Broken/Fractured Bones
- ❑ ***Circulatory Problems
- ❑ ***Heart Problems
- ❑ Pacemaker
- ❑ Seizures/Convulsions
- ❑ Strokes
- ❑ Speech Difficulty
- ❑ Loss of Memory
- ❑ ***Respiratory Problems
- ❑ Eye/Vision Problems
- ❑ Tension
- ❑ Fatigue
- ❑ Ear/Hearing Problems
- ❑ Dizziness/Fainting
- ❑ Loss of Bladder Control
- ❑ ***Digestion Problems
- ❑ Diarrhea
- ❑ Constipation
- ❑ Nausea
- ❑ ***Cancer
- ❑ ***Tumors
- ❑ Female Problems
- ❑ Irritability
- ❑ Anxiety
- ❑ Prostate Problems
- ❑ Depression
- ❑ Gall Bladder Problems
- ❑ Drug Addiction
- ❑ Alcoholism
- ❑ Nervousness
- ❑ Headaches/Migraines (How often? _____)
- ❑ Pain/Tension/Numbness (How often? _____)
  - ❑ Neck ❑ Legs ❑ Shoulders
  - ❑ Arms ❑ Hands ❑ Low Back

Please explain any items with a * _____

_____

Reason for today's visit:

_____

Have you ever been to a Chiropractor before? Yes No

Payment Information

How will payment be made: Cash Check Credit Card Insurance

Insurance company Name:_____ ID Number:_____

Please allow us to make a copy of your insurance card so we can verify your benefits

This office conforms to the current HIPPA Guidelines. You may request a copy of our HIPPA Policy at the front desk.

Please initial to indicate you have been made aware of its availability: Initials: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____ **Date** _____

Guardian Signature _____ **Date** _____