A Touch of Health
Confidential Patient Health Record

Today's Date: _____

Personal Information

First:_____ Middle:_____ Last: _____ Sex: Male / Female

Social Security #: _____-_____-_____ Birth Date: _____ /_____/_____ Age:_____

Address: _____Apt # _____

City: _____ State: _____ Zip: _____ Email Address: _____

Would you like to receive our newsletter via email? : □ Yes or □ No

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

Work Phone: (_____)_____-_____-Ext_____

Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Partnered

Business Name: _____Occupation/Job Title: _____

Business Address: _____

City_____State_____Zip Code_____

Referred By:_____

Current Health Condition

Unwanted Condition (Why are you here today?):_____

_____

Please Label on the Diagram the Area of Discomfort

→ → → → → → →

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? □ Yes □ No. When? _____

Is the Condition: □ Auto Related □ Job Related □ Home Injury

□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

Explain: _____

_____

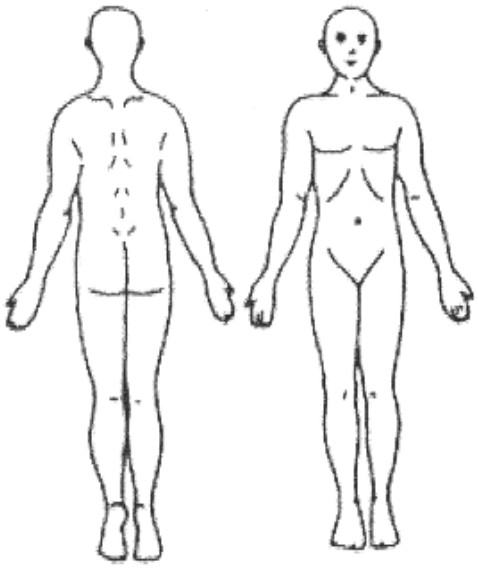
Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N=Numbness

P= Pins & Needles S=Stabbing



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