

PRINT NAME: _____

FILE # _____

Confidential Patient Health Record

“GEORGE’S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST”

Instructions: Please check off the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
 1. High Blood Pressure (hypertension) Yes No
 2. Hardening of the arteries (arteriosclerosis) Yes No
 3. Diabetes Yes No
 4. Heart or blood vessel diseases Yes No
 5. Bone spurs on the neck bones (cervical spondylosis) Yes No
 6. Whiplash injury (flexion-extension injury) (cervical spondylosis) Yes No
 7. Have any of your relatives suffered a stroke? Yes No
 8. Were you ever a smoker? If yes, from _____ to _____ Yes No
 9. Do you take any medications on a regular basis? Yes No
 - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)

- 10. (Woman Only) Have you ever taken oral Contraceptives? Yes No
 - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?
 1. Blurred Vision Yes No
 2. Double Vision Yes No
 3. Diminished or partial loss of vision in one or both eyes Yes No
 4. Complete loss of vision in one or both eyes Yes No
 5. Ringing, buzzing or any noise in the ear(s) Yes No
 6. Hearing loss in one or both ears Yes No
 7. Slurred speech or other speech problems Yes No
 8. Difficulty swallowing? Yes No
 9. Dizziness Yes No
 10. Temporary lack of understanding Yes No
 11. Loss on consciousness, even momentary blackouts Yes No
 12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? Yes No
 13. Any other abnormal sensations in any part of your body Yes No
 14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs Yes No
 15. Sudden collapse without loss of consciousness Yes No

Our Purpose at Bak Chiropractic is to help as many people of this community as possible achieve maximum health through chiropractic care, guidance and education.

Payment for service is expected at the time they are rendered. We accept cash, checks, Visa, and MasterCard.

We bill your insurance company for their portion of the bill as a courtesy. Checks sent to you by mistake must be sent to our office within three days.

Workers compensation and auto accident patients are expected to supply this office, in a timely manner, with any and all necessary information needed to file your claims.

I hereby authorize the Doctor to treat my condition as she or he deems appropriate.

The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____

Date _____