2114 Schofield Ave. Weston, WI 54476

PATIENT HEALTH HISTORY

❑ New Patient
❑ Reactivate (1year)

Today's Date:______________

Personal Information

Name:		Home Phone:
Street Address:		Work Phone:
City/State/Zip:		Cell Phone:
Social Security #:		Date of Birth:
Driver's License#:	Email:	
Emergency Contact:	Emergency Contact's Phone:	

Social Health History

Status: ❑ Male ❑ Female ❑ Single ❑ Married ❑ Other:____________ ❑ Student: ❑ Full-Time ❑ Part-Time

Occupation:____ Employer:____

Work Hours Per Week:_______ Recreational Activities (Hobbies): ______________________________

❑ Yes ❑ No Do You Commute to Work? How Far? ______________________________

❑ Yes ❑ No Do You Exercise? Times Per ______________________________

❑ Yes ❑ No Are You a Smoker? Packs Per Day? ______________________________

❑ Yes ❑ No Do You Consume Caffeine? How Much Per Day? ______________________________

❑ Yes ❑ No Do You Consume Alcohol? Glasses Per Day / Week? ______________________________

Spouse's Name:______________________________Spouse's Employer: ______________________________

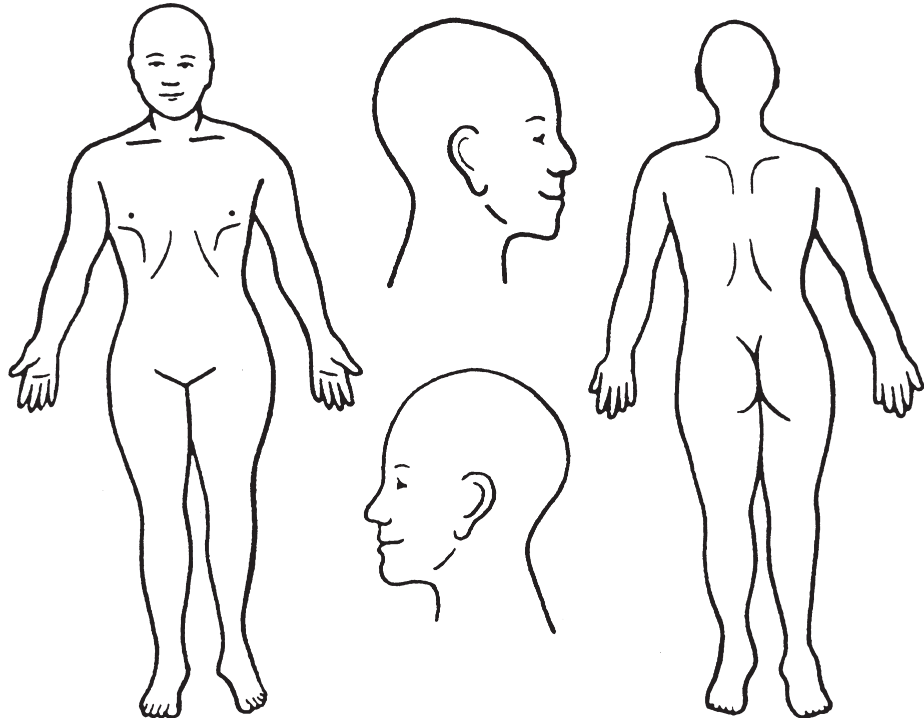
Names / Ages of Children at Home:______________________________Spouse's DOB: ____________________

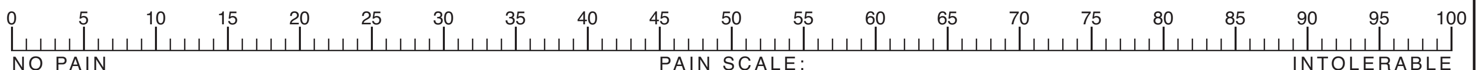
Who is Your Medical Doctor?______________________________Medical Doctor City / State: ______________________

Chief Complaint

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation. Use the appropriate symbols. If there is more than one area of discomfort, please rate the pain on a scale of 0 to 100 next to each are, with 0 being no pain and 100 being intolerable pain.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)





NO PAIN PAIN SCALE: INTOLERABLE

Symptoms Developed From: ❑ Work-Related Injury ❑ Auto Accident ❑ Other

1. When did they begin? ____________________
2. What is your major symptom? ____________________
3. What does this prevent you from doing or enjoying? ____________________
   ____
4. If this is a recurrence, when was the first time you noticed this problem? ____________________
   How did it originally occur? ____________________
   Has it become worse recently? Yes____ No____ Same____ Better____ Gradually Worse____
   If yes, when and how? ____________________
5. How frequent is the condition? Constant____ Daily____ Intermittent____ Night Only____
   How long does it last? All Day____ Few Hours____ Minutes____
6. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes____ No____. If yes, describe ____________________
7. Is there anything you can do to relieve the problem? Yes____ No____. If yes, describe ____________________
   ____________________. If no, what have you tried to do that has not helped? ____________________
   ____
8. What makes the problem worse? Standing____ Sitting____ Lying____ Bending____ Lifting____ Twisting____
   Other ____________________
9. Does the pain interfere with your sleep? Yes____ No____. How many times do you wake up? ____________________
10. Do you sleep with a pillow? Yes____ No____. If so, how many?____ What position do you sleep in? ____________________
11. Does heat affect the pain? Yes____ No____. How? ____________________
12. Does cold affect the pain? Yes____ No____. How? ____________________
13. Do you wear a heel lift? Yes____ No____. If so, which side? ____________________
14. **Headaches** - Do you experience: Not Applicable ❑
    Nausea, vomiting, or visual disturbances? Yes____ No____
    Pain or cracking in jaw? Yes____ No____
    Abnormal blood pressure? Yes____ No____
    Family history of headaches? Yes____ No____
    Frequency of headaches: ____________________ Eye exam date: ____________________
15. **Cervical Spine (neck):** Not Applicable ❑
    Neck injury that affects hearing? Yes____ No____
    Vision, balance, or ringing in ears? Yes____ No____
    Do you hear grating sounds? Yes____ No____
    Family history of headaches? Yes____ No____
    Difficulty turning head? Right____ Left____
    Pain / pressure behind eyes? Yes____ No____
    Feeling of ripping or tearing? Yes____ No____. Where: ____________________
16. **Lumbosacral Spine (low back):** Not Applicable ❑
    Feeling of ripping or tearing? Yes____ No____. Where: ____________________
    Does pain radiate to the abdomen? Yes____ No____
    Impairment of bowel or urinary function? Yes____ No____. Explain: ____________________
17. Have you had any broken bones? Yes____ No____. If yes, please list and give dates ____________________
    ____
18. Women Only: Are you pregnant or is there any possibility you may be pregnant? Yes____ No____ Uncertain____

System Review Questions

Have you had any problems with the following areas? (Please mark Y for Yes or N for No in each of the following:)

1.___ Eyes
2.___ Ears, Nose, Mouth, Throat
3.___ Heart
4.___ Lungs/Breathing
5.___ Intestines
6.___ Urinary
7.___ Muscles
8.___ Nerves
9.___ Skin
10.___ Psychological
11.___ Internal Organs
12.___ Blood
13.___ Allergies
14.___ Other ____________________
____

Please Describe: ____________________
____

ADDITIONAL COMMENTS: ____________________
____
____

Past Medical History

How many times have you had the condition that you are seeing us for today? ❑ 0-3 Times ❑ 4 Or More Times

❑ Yes ❑ No Do you suffer from any condition other than that for which you are now consulting us? (Diabetes, High Blood Pressure, Arthritis, etc.) If yes, what?______________________________

❑ Yes ❑ No Have you ever seen a chiropractor before?

Date	Dr. Name	Condition	Results	
1.			❑ Complete Recover	❑ Complications
2.			❑ Complete Recover	❑ Complications

❑ Yes ❑ No Have you ever seen a Doctor for this Condition?

Date	Dr. Name	Condition	Results	
1.			❑ Complete Recover	❑ Complications
2.			❑ Complete Recover	❑ Complications

❑ Yes ❑ No Allergies? To what? ______________________________

❑ Yes ❑ No Do you now take prescription drugs, over-the-counter drugs, vitamins, or supplements?

PRODUCT / DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
1.				
2.				
3.				

❑ Yes ❑ No Have you ever had major illnesses, injuries, falls, hospitalizations, auto accidents, or surgeries?

Date	Dr. Name	Condition	Results	
1.			❑ Complete Recover	❑ Complications
2.			❑ Complete Recover	❑ Complications
3.			❑ Complete Recover	❑ Complications

Family Health History

Health Status of Family Members. (If deceased, from what?)

Mother: ______________________________

Father: ______________________________

Sisters: ______________________________ How many? __________

Brothers: ______________________________ How many? __________

Children: ______________________________ How many? __________

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. I also give permission for my case to be used for research purposes if it is so approved.

patient signature:______________________________ Date: __________

guardian/legal representative signature:______________________________ Date: __________

d.c./c.a. signature:______________________________ Date: __________

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefor it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be full informed in consenting to treatment.

Chiropractic offices use trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your Chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific risk possibilities associated with Chiropractic care:

Stroke– Stroke is the most serious complication of Chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located withing the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 to 5.85 million treatments. (CMAJ 2001 Oct. 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). The results of a retrospective study conducted by Haldeman S, Et. Al, suggested that stroke should be considered a random and unpredictable complication of any neck movement including cervical manipulation (J Neurol 2002 Aug: 249(8): 1098-104).

Soreness– Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While is is not general dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

Soft Tissue Injury– Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury– Manual adjustments to the thoracic spine, in rare cases, May cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns– Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

Other Problems– There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is your goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Name Printed ______________________

Today's Date ______________________

Patient's Signature ______________________

Parent of Guardian Signature for Minor ______________________