Health by Hands CHIROPRACTIC

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New Berlin, WI 53151

Confidential Patient Information

Name: _____ Date of Birth ____/____/____ Age ____ Sex: M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Would you like to receive office communication via email? ☐ Yes ☐ No

Marital Status M D S W Spouse Name _____ #Children _____

Occupation _____ Employer _____ School _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Primary Care Doctor _____ Phone Number _____ May we contact them? ☐ Yes ☐ No

Health Insurance Company _____ Phone Number _____ ID _____

Group Number _____ Insured's Name _____ Insured's Date of Birth ____/____/____

Main Complaint: _____

Are your current problems due to an injury? ☐ Yes ☐ No Date of injury ____/____/____

If yes, was the injury ☐ On the job ☐ At work If yes, has this incidence been reported? ☐ Yes ☐ No

Is the injury case still open? ☐ Yes ☐ No Have you retained an attorney ☐ Yes ☐ No

If yes, attorney name _____

How did you hear about our office? _____

Why did you come into our office and what is your expectation of us? _____

_____

How would you like us to handle your problem? ☐ Maximum Correction OR ☐ Temporary Relief

Had past chiropractic care? ☐ Yes ☐ No When? _____ Had spinal x-rays in the last year? ☐ Yes ☐ No

Please list all surgeries, falls, auto accidents and injuries (regardless how severe) with dates _____

_____

Medications:

Please list all prescription, over the counter medications or nutritional supplements you are taking

Name Purpose Dosage

_____

_____

_____

_____

Please list all known allergies _____

HEALTH HISTORY – Please mark all that apply (past or present)

General Systems
☐ Cancer
☐ Diabetes
☐ Headache
☐ Epilepsy
☐ Hernia
☐ Loss of Sleep/Fatigue
☐ Stroke
☐ Broken Bones

Gastrointestinal
☐ Heartburn/Reflux
☐ Constipation
☐ Diarrhea
☐ Excessive hunger/thirst

Spine
☐ Herniated Disc
☐ Neck pain R/L
☐ Jaw pain/click R/L
☐ Mid back pain R/L
☐ Low back Pain R/L
☐ Numbness/tingling in arms/legs R/L
☐ Shoulder pain R/L
☐ Elbow pain R/L
☐ Wrist/Hand pain R/L
☐ Hip pain R/L
☐ Knee pain R/L
☐ Ankle/Foot pain R/L

Genito-Urinary
☐ Blood in urine
☐ Frequent urination
☐ Loss bowel/bladder function

Cardiovascular
☐ Shortness of breath
☐ High/Low Blood Pressure
☐ Light headed (positional)
☐ Pacemaker
☐ Heart attack
☐ High cholesterol
☐ Chest pain

Miscellaneous
☐ Night pain
☐ Pain wakes you from sleep
☐ Unexplained weight loss/gain

Respiratory
☐ Allergy
☐ Asthma
☐ Chronic Cough

Skin
☐ Eczema/Psoriasis
☐ Bruise easily
☐ Hives

Women only
☐ Birth control
☐ Breast Implant
☐ Pregnant ☐ Unsure
☐ Not pregnant

Social History

☐ Smoking: packs/day ☐ Never Smoker ☐ Former Smoker

Number caffeinated beverages per day _____ Exercise type and frequency: _____

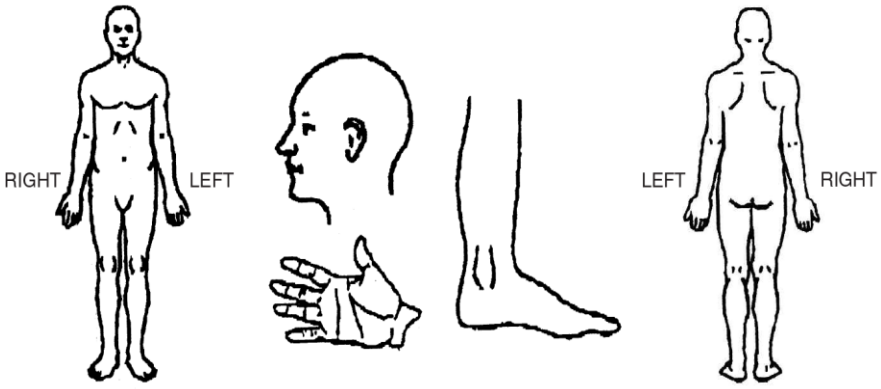
Number alcoholic beverages per week _____ Do you use recreational drugs? _____

Family History

	Diabetes	Heart Disease	Cancer	Hypertension
Parent	☐	☐	☐	☐
Sibling	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐

Please circle area and type of pain on the drawings using the codes listed below

N - Numbness	TH - Throbbing
P - Pain	MSP – Muscle Spasm
SH - Sharp	SHO - Shooting
T - Tingling	B - Burning
A - Ache	C - Cramps
D - Dull	SW - Swelling
S - Soreness	O - Other
ST - Stiffness	



BELOW: list your symptoms, from <u>most severe</u> to <u>mildest</u>, and include ANY and ALL areas that bother you including knees, shoulders, hands, feet, ear infections, headaches, jaw, etc.

Worst symptom:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

Symptom 2:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

Symptom 3:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____
