Pro Health Chiropractic

New Patient Health History

1777 W. Main Street
Sun Prairie, WI 53590
(608) 318-2410

Name:		Today's Date:
Date of Birth:	Age:	☐Male ☐Female
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Email:
Best way to contact you: ☐Call Home ☐Call Cell ☐Text Cell Carrier: _____ ☐Email		
Parent Name (If Minor):	Phone Number:	

Referral Information

How did you hear about our office?

Emergency Information

Emergency Contact:	
Phone:	Relationship:

Current Health Condition

Chief Complaint: (Why are you here today?)

_____
_____
_____

Body Area Involved	☐Neck ☐Mid-Back ☐Low-Back ☐Upper Extremity ☐Lower Extremity ☐Other: _____
Condition	☐New (<6 weeks) ☐Exacerbation ☐Recurring ☐Chronic (>6 Weeks)
Onset Mechanism	☐Auto ☐Work ☐Over Exertion ☐Slip/Fall ☐Lifting ☐Repetitive Motion ☐Slept Wrong ☐No Injury ☐Unknown ☐Other: _____
Symptoms	☐Pain ☐Stiffness ☐Numbness ☐Weakness
Location	☐Left ☐Right ☐Bilateral (Both Sides)
Quality	☐Burning ☐Dull/Aching ☐Sharp ☐Shooting ☐Stabbing ☐Throbbing ☐Tightness ☐Tingling ☐Diffuse ☐Localized ☐Radiating ☐Other: _____
Resting Pain Scale	0 1 2 3 4 5 6 7 8 9 10
Activity Pain Scale	0 1 2 3 4 5 6 7 8 9 10

When did symptoms start?			
When did they get worse?			
When did you have them last?			
Has this happened before?		If yes, When?	
Did a specific injury occur?		If yes, When?	
Did a specific accident occur?		If yes, When?	

When are the symptoms worst?	☐Morning ☐Afternoon ☐Evening ☐With Activity ☐Constant ☐Intermittent
Associated Signs & Symptoms	☐Blurred Vision ☐Nausea ☐Sleep Disturbance ☐Depression ☐Ringing In Ears ☐Irritability/Mood Swing ☐Stiffness ☐Dizziness ☐Localized Tingling ☐Headaches (☐Dull ☐Sharp ☐Throbbing ☐Stabbing ☐Aura) ☐Radiating (☐Left ☐Right) ☐Weakness (☐Left ☐Right)
Other Signs & Symptoms	☐Aches ☐Fever ☐Numbness ☐Runny Nose ☐Tingling ☐Cold Limb ☐Heartburn ☐Pale Bluish Skin ☐Joint Stiffness ☐Vomiting ☐Dizziness ☐Muscle Spasm ☐Panic ☐Sweating ☐Weakness ☐Fatigue ☐Nausea ☐Pins & Needles ☐Swelling
Symptoms ***Better*** With	☐Activity ☐Bending ☐Cold ☐Heat ☐Massage ☐OTC Meds ☐RX Meds ☐Rest ☐Stretching ☐Sitting ☐Standing ☐Walking ☐Nothing Helps

Employment		
Occupation:		Hours Worked Per Day:
Job Classification	☐Sedentary ☐Light Lifting ☐Moderate Lifting ☐Heavy Lifting	
Lifting	☐Constant (66-100%) ☐Frequent (33-65%) ☐Occasional (0-32%)	
Work Activities	☐Sitting ☐Standing ☐Walking ☐Climbing ☐Pushing ☐Pulling ☐Kneeling ☐Reaching☐Twisting ☐Bending	
Repetitive Activities	☐Computer ☐Phone ☐Machinery ☐Assembly ☐Hand Tools ☐Grasping	
Effect on Job Performance	☐Mild Painful (Can Do) ☐Moderate Painful (Can Do Limited) ☐Severe (Unable to perform) ☐Other: _____	

Daily Activities: To what level are you experiencing symptoms while performing these activities? 0 – No Effect ➡ 10 – Unable to do																						
Activity	0	1	2	3	4	5	6	7	8	9	10		Activity	0	1	2	3	4	5	6	7	8	9	10
Bending													Bathing											
Carrying Groceries													Kneeling											
Change Sit to Stand													Sleep											
Child Care													Sitting											
Climb Stairs													Standing											
Computer Use													Yard Work											
Pet Care													Exercise											
Driving													Running											
Household Chores													Golf											
Lifting													Walking											
Reading													Swimming											
Dressing													Weight Lifting											

Past Health History – Please fill out carefully as these problems can affect your overall course of care	
Childhood Illness: ☐Deny Childhood Illness	☐ADD ☐Allergies/Hay fever ☐Asthma ☐Eczema ☐Bed Wetting ☐Cerebral Palsy ☐Chicken Pox ☐Depression ☐Diabetes ☐Ear Infections ☐Fetal Drugs ☐ Food Allergies ☐Headaches ☐Hepatitis ☐HIV ☐Measles ☐Mumps ☐Rash ☐Scoliosis ☐Sickle Cell ☐Spina Bifida ☐Other: _____
Adult Illness: ☐Deny Adult Illness	☐Alzheimer's ☐Anemia ☐Arthritis ☐Asthma ☐Cancer ☐Chicken Pox ☐Crohn's/Colitis ☐CRPS (RSD) ☐CVA (Stroke) ☐Kidney Disease ☐Depression ☐Diabetes 1 ☐Diabetes 2 ☐Ear Infections ☐Emphysema ☐Eye Problems ☐Fibromyalgia ☐Heart Disease ☐Hepatitis ☐HIV ☐Hypertension ☐Influenza ☐Pneumonia ☐Liver Disease ☐Lung Disease ☐Lupus (Discoid) ☐Lupus (Systemic) ☐Multiple Sclerosis ☐Parkinson's ☐Pleurisy ☐Psychiatric Problems ☐Scoliosis ☐Seizure Disorder ☐Shingles ☐STD's (Unspecified) ☐Suicide Attempt(s) ☐Thyroid ☐Vertigo ☐Past history of similar symptoms ☐Other: _____

Surgeries: ☐Deny Surgeries	☐Angioplasty ☐Appendectomy ☐Caesarean Section ☐Cardiac Catheterization ☐Carpal Tunnel Repair ☐Coronary Artery Bypass ☐Cosmetic ☐D & C ☐Dental Surgery ☐Gall Bladder ☐Hemorrhoidectomy ☐Hernia Repair ☐Hysterectomy ☐Joint Reconstruction ☐Joint Replacement ☐Laminectomy ☐Mastectomy ☐Pacemaker Insertion ☐Rotator Cuff ☐Spinal Fusion ☐Tonsillectomy ☐Other:_____
OB/GYN: ☐Deny OB/GYN Issues	☐I have never been pregnant ☐I have been pregnant in the past (# of pregnancies: _____) ☐Complicated pregnancy ☐Uncomplicated pregnancy ☐C-section delivery ☐Vaginal delivery ☐I am currently pregnant
Injuries:	☐Back Injury ☐Broken Bones ☐Fracture ☐Severe Fall ☐Head Injury ☐Disability ☐Industrial Accident ☐Joint Injury ☐Severe Laceration ☐Motor Vehicle Accident ☐Mild/Moderate Soft Tissue Injury ☐Severe Soft Tissue Injury

Previous Treatment

Have you seen other doctors for this condition? ☐No ☐Yes – Name: _____
Office Location: _____
Describe Treatment:_____

Please list or attach a copy of all Vitamins, Supplements, Rx and OTC Drugs you currently take and dosages

What would you love to be doing that you are unable to do now?	
What would you love to be doing better that you can already do now?	

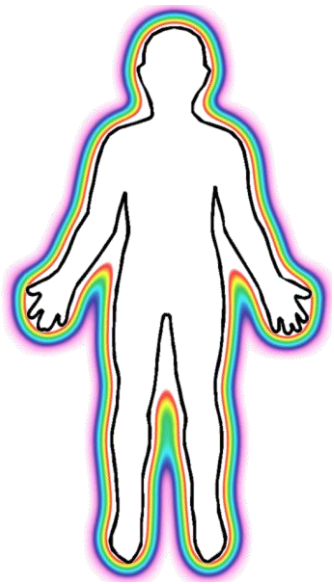
AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Signature		Date:

Please Circle Areas of Complaint. Use the following letters to describe your symptoms:

S – Stiffness
B – Burning
N – Numbness
P – Sharp Pain
T – Tingling
D – Dull Pain



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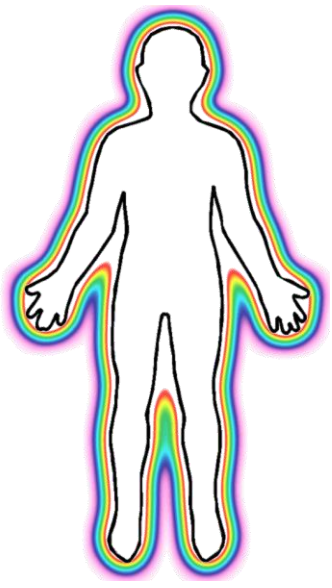

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