

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 |
| Primary Complaint: |
| 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 |
| How often? | [ ] 0-25% of the day [ ] 25-50% of the day [ ] 50-75% of the day [ ] 75-100% of the day |
| When are the symptoms worst? | [ ] Morning [ ] Afternoon [ ] Evening [ ] With Activity [ ] Constant [ ] Intermittent |
| When did symptoms start? |  |
| When did they get worse? |  |
| When did you have them last? |  |
| Has this happened before? |  | If yes, When? | Z |
| Did a specific injury occur? |  | If yes, When? |  |
| Did a specific accident occur? |  | If yes, When? |  |

|  |  |
| --- | --- |
| Associated Signs & Symptoms | [ ] Blurred Vision [ ] Nausea [ ] Sleep Disturbance [ ] Depression [ ] Ringing In Ears [ ] Irritability/Mood Swing [ ] Stiffness [ ] Dizziness [x] 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 |
|  |
|  |
| Secondary Complaint: |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Has this happened before? |  | If yes, When? |  |
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| Did a specific accident occur? |  | If yes, When? |  |
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| 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 [ ] 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 |  |  |  |  |  |  |  |  |  |  |  |  | Static Sitting |  |  |  |  |  |  |  |  |  |  |  |
| Climb Stairs |  |  |  |  |  |  |  |  |  |  |  |  | Static Standing |  |  |  |  |  |  |  |  |  |  |  |
| Computer Use |  |  |  |  |  |  |  |  |  |  |  |  | Yard Work |  |  |  |  |  |  |  |  |  |  |  |
| Pet Care |  |  |  |  |  |  |  |  |  |  |  |  | Exercise |  |  |  |  |  |  |  |  |  |  |  |
| Driving |  |  |  |  |  |  |  |  |  |  |  |  | Running |  |  |  |  |  |  |  |  |  |  |  |
| Household Chores |  |  |  |  |  |  |  |  |  |  |  |  | Golf |  |  |  |  |  |  |  |  |  |  |  |
| Lifting |  |  |  |  |  |  |  |  |  |  |  |  | Walking |  |  |  |  |  |  |  |  |  |  |  |
| Reading |  |  |  |  |  |  |  |  |  |  |  |  | Swimming |  |  |  |  |  |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |  |  |  |  |  |  | Other: |  |  |  |  |  |  |  |  |  |  |  |

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| --- |
| Past Health History – Please fill out carefully as these problems can affect your overall course of care |
| ***Childhood Illness:*** [ ] ADD [ ] Allergies/Hay fever [ ] Asthma [ ] Eczema [ ] Bed Wetting[ ] Deny Childhood [ ] Cerebral Palsy[ ] Chicken Pox [ ] Depression [ ] Diabetes [ ] Ear Infections Illness [ ] Fetal Drugs [ ]  Food Allergies [ ] Headaches [ ] Hepatitis [ ] HIV  [ ] Measles [ ] Mumps [ ] Rash [ ] Scoliosis [ ] Sickle Cell [ ] Spina Bifida [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Adult Illness:*** [ ] Alzheimer’s [ ] Anemia [ ] Arthritis [ ] Asthma [ ] Cancer [ ] Chicken Pox [ ] Deny Adult [ ] Crohn’s/Colitis [ ] CRPS (RSD) [ ] CVA (Stroke) [ ] Kidney Disease [ ] Depression Illness [ ] 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:*** [ ] Angioplasty [ ] Appendectomy [ ] Caesarean Section [ ] Cardiac Catheterization [ ] Deny Surgeries [ ] 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:*** [ ] I have never been pregnant [ ] I have been pregnant in the past (# of pregnancies: \_\_\_\_\_\_\_\_) [ ] Deny OB/GYN [ ] Complicated pregnancy [ ] Uncomplicated pregnancy [ ] C-section delivery  Issues [ ] 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: |

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***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

Front

Back