

New Patient Health History

1777 W. Main Street

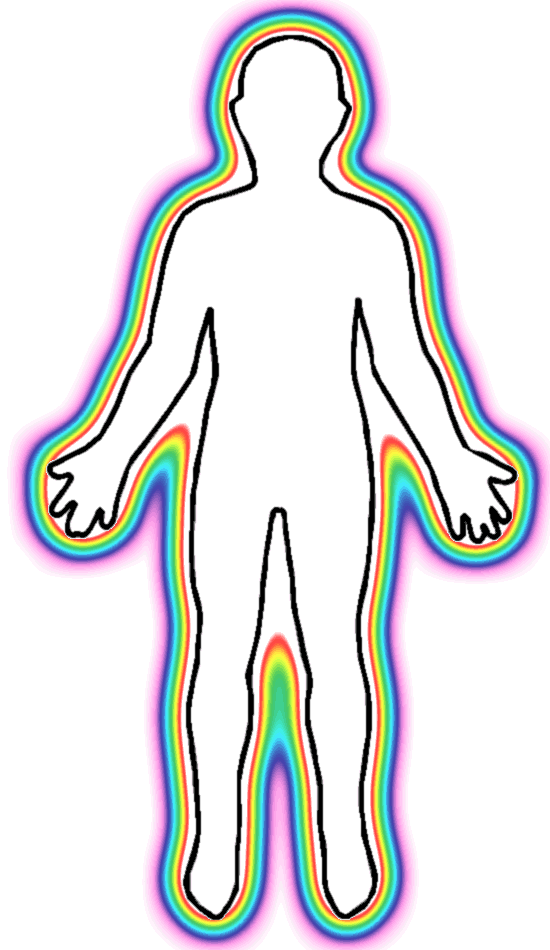
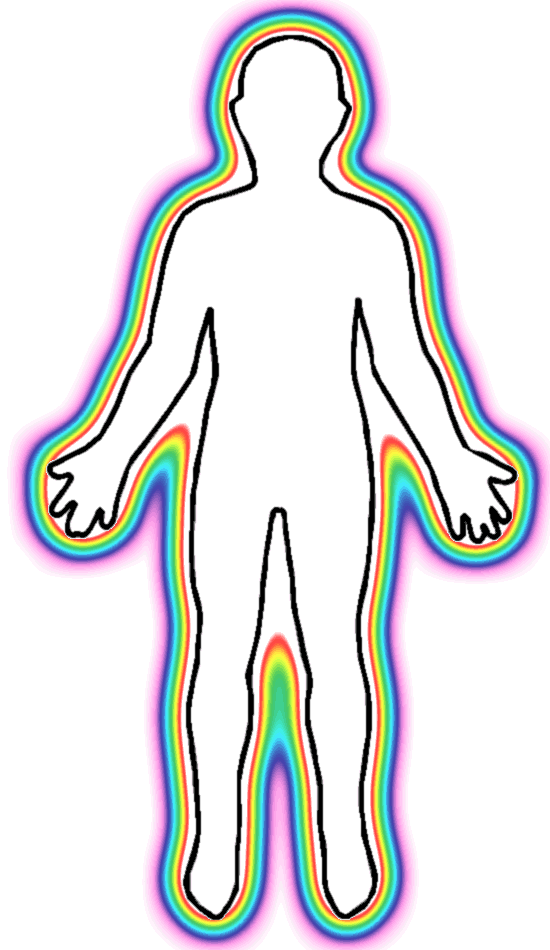
Sun Prairie, WI 53590

(608) 318-2410

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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? | | | |  | |

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| 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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? | | | | | |  | | | | | | | |
| 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 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 ReachingTwisting 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 PalsyChicken 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 DiseaseHepatitis 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: |



***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