CHIROPRACTIC • NEUROLOGY • REGENERATION

Initial Assessment Forms

Please fill out the following forms and turn into our office via:

Fax: (608) 318-2410

Email: admin@prohealthsp.com

Dropping off during office hours:

1777 W. Main Street

Sun Prairie, WI 53590

Based on this initial intake, we will contact you to schedule your appointment with our Neurology Department.

Upon scheduling, we will provide you with additional forms to fill out prior to your initial examination with Pro Health.

All forms must be completed in order to begin care in our Neurology department.

If you need assistance, please contact our office at

(608) 318-2410

Patient Demographics

_____

Last Name First Name M.I. Date

_____

Gender Age Date of Birth

Circle Status: Married Single Partnered Widowed Separated Divorced

_____

Street Address City State Zip

_____

Home Phone Mobile Phone Work Phone

Emergency Contact

_____

Name/Relationship Best Contact Phone Number

Employment Information

_____

Employer Name Occupation

Patient Account

Are you here because you were injured in a:

☐Vehicle Collision ☐Work Related Injury ☐Other ☐None of these

Insurance Information

Company Name: _____ Insured's Name: _____

Insured's SSN: ____-___-_____ Birth Date: ____/____/____ Employer of Insured: _____

Health Complaints

What is your primary complaint? _____

When did it start? _____

Have your symptoms changed? _____ How? _____

Is your primary complaint: ☐Local ☐Widespread

Did it come on: ☐Immediately ☐Rapidly ☐Gradually

Using the scale below, rate how your **primary** complaint affects your life (circle box below):

0	1	2	3	4	5	6	7	8	9	10
No pain or discomfort	Complaint causes slight discomfort	Complaint that does not affect my activity	Complaint that rarely affects my daily activities	Complaint that often affects my daily activities	Complaint that impedes my daily activities	Complaint that impedes my work/school schedule	Complaint that prevents me from working at all	Complaint that prevents me from working and all physical activity	Complain that keeps me bedridden	Complaint that causes thoughts of suicide

Lifestyle

List any prescription or over-the-counter medications you are currently taking (or attach med list)

Medication/Reason

1. _____ 3. _____

2. _____ 4. _____

How many hours of television do you watch per day? ☐<1 ☐1-2 ☐3-5 ☐>5

How many hours a day do you use a computer (work or home)? ☐<1 ☐1-2 ☐3-5 ☐>5

How may hours a day do you ride in a car or other vehicle? ☐<1 ☐1-2 ☐3-5 ☐>5

How often do you exercise? _____ What type of exercise? _____

How often do you use tobacco? ☐Never ☐Daily ☐Monthly

How many servings of alcohol do you consume weekly? ☐<1 ☐1-2 ☐3-5 ☐>5

How many servings of caffeine do you consume weekly? ☐<1 ☐1-2 ☐3-5 ☐>5

How many servings of soda do you consume weekly? ☐<1 ☐1-2 ☐3-5 ☐>5

Please list children & ages below:

_____

_____

Rate your stress level: _____ (0 = No Stress – 10 = Severe Stress)

Please list all previous surgeries and hospitalizations – include dates:

_____

_____

Please list all allergies or sensitivities: _____

_____

Please list all dates of motor vehicle collisions, if any: _____

_____

Please list any fractures or dislocations: _____

Women Only:

Are you pregnant? ☐Yes ☐No Taking Birth Control? ☐Yes ☐No

Date of Last Menses: _____

Medical History

Mark the following conditions as they pertain to you:

Alcoholism	☐Yes ☐No	Heart Problems	☐Yes ☐No	Irritable Bowel	☐Yes ☐No	Allergies	☐Yes ☐No
Anemia	☐Yes ☐No	Diabetes	☐Yes ☐No	Bladder Problems	☐Yes ☐No	Asthma	☐Yes ☐No
Arthritis	☐Yes ☐No	Stroke	☐Yes ☐No	Stomach Problems	☐Yes ☐No	Ulcer	☐Yes ☐No
Cancer	☐Yes ☐No	Low Back Pain	☐Yes ☐No	Thyroid Disorder	☐Yes ☐No	Acid Reflux	☐Yes ☐No
Epilepsy	☐Yes ☐No	Head Pain	☐Yes ☐No	Sleep Disorders	☐Yes ☐No	AIDS	☐Yes ☐No
Appendicitis	☐Yes ☐No	Arteriosclerosis	☐Yes ☐No	Breast Lumps	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chicken Pox	☐Yes ☐No	Exzema	☐Yes ☐No	Emphysema	☐Yes ☐No	Lyme Disease	☐Yes ☐No
Fibromyalgia	☐Yes ☐No	Goiter	☐Yes ☐No	Gout	☐Yes ☐No	Heart Disease	☐Yes ☐No
Measles	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Mumps	☐Yes ☐No	Pacemaker	☐Yes ☐No
Pneumonia	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
STD	☐Yes ☐No						

Please describe any other medical issues you have had in your past and treatments:

_____

_____

_____

Have you ever been knocked out, had a lapse in memory or injured in your head or neck?

☐Yes ☐No

If yes, please explain: _____

_____

Family History

Please share any significant family history, relationship and disease such as diabetes, heart disease, cancer, etc.:

_____

_____

_____

Current Complaints

Please check the appropriate box for any of the following symptoms that you have had now or previously. This is a confidential health report.

Please add a letter next to the symptom: C = Current; P = Past

Cardiovascular	**Respiratory**	**Skin**	**Genitourinary**
☐Hardening of the Arteries	☐Chronic Cough	☐Bruise Easily	☐Bed-Wetting
☐High Blood Pressure	☐Difficulty Breathing	☐Dryness	☐Blood in Urine
☐Low Blood Pressure	☐Wheezing	☐Skin Eruptions (rash)	☐Frequent Urination
☐Pain over Heart	☐Spitting up Blood	☐Discolorations	☐Kidney Infection
☐Poor Circulation	☐Spitting up Phlegm	☐Varicose Veins	☐Kidney Stones
☐Rapid Heart Beat			☐Painful Urination
☐Chest Pain			☐Pus in Urine

Eyes, Ears, Nose, Throat	**Gastrointestinal**	**Women Only**	**Nervous System**
☐ Eye Pain Strain	☐ Appetite Changes	☐ Back Ache/Cramps	☐ Numbness/Tingling
☐Vision Problems	☐ Difficulty Chewing or Swallowing	☐ Excessive Menstrual Flow	☐ Loss of Feeling
☐Ear Pain	☐ Excessive Thirst	☐ Hot Flashes	☐ Paralysis
☐ Ear Noises	☐ Nausea	☐ Irregular Cycle	☐ Dizziness
☐ Ear Discharge	☐ Vomiting Blood	☐ Menopausal Symptoms	☐ Fainting
☐ Hearing Loss	☐ Abdominal Pain	☐ Painful Menstruation	☐ Headache
☐ Nose Pain	☐ Diarrhea	☐ Vaginal Discharge	☐ Loss of Memory
☐ Nose Bleeds/Discharge	☐ Constipation	☐ Vaginal Pain	☐ Muscle Jerking
☐ Nasal Obstruction	☐ Bloody/Black Stool	☐ Breast Pain	☐ Loss of Taste/Smell
☐ Sore Mouth	☐ Hemorrhoids	☐ Miscarriage	☐ Cold Feet/Hands
☐ Sore Throat	☐ Liver Problems		☐ Convulsions
☐ Hoarseness	☐ Gallbladder Problems		☐ Confusion
☐ Difficult Speech	☐ Weight Trouble		☐ Depression
☐ Sinus Infection			☐ Insomnia
☐ Jaw Pain			

Musculoskeletal		**Pain, Numbness, Cramp**	
☐ Low Back Pain	☐ Stiff Joints	☐ Back	☐ Hands
☐ Mid Back Pain	☐ Sore Muscles	☐ Neck	☐ Hips
☐ Neck Pain	☐ Weak Muscles	☐ Head	☐ Legs
☐ Arm Problems	☐ Muscle Spasm	☐ Shoulders	☐ Knees
☐ Leg Problems	☐ Walking Problems	☐ Shoulders	☐ Feet
☐ Swollen Joints	☐ Sciatica	☐ Arms	☐ Other: _____

☐ Painful Joints ☐ Arthritis ☐ Elbows

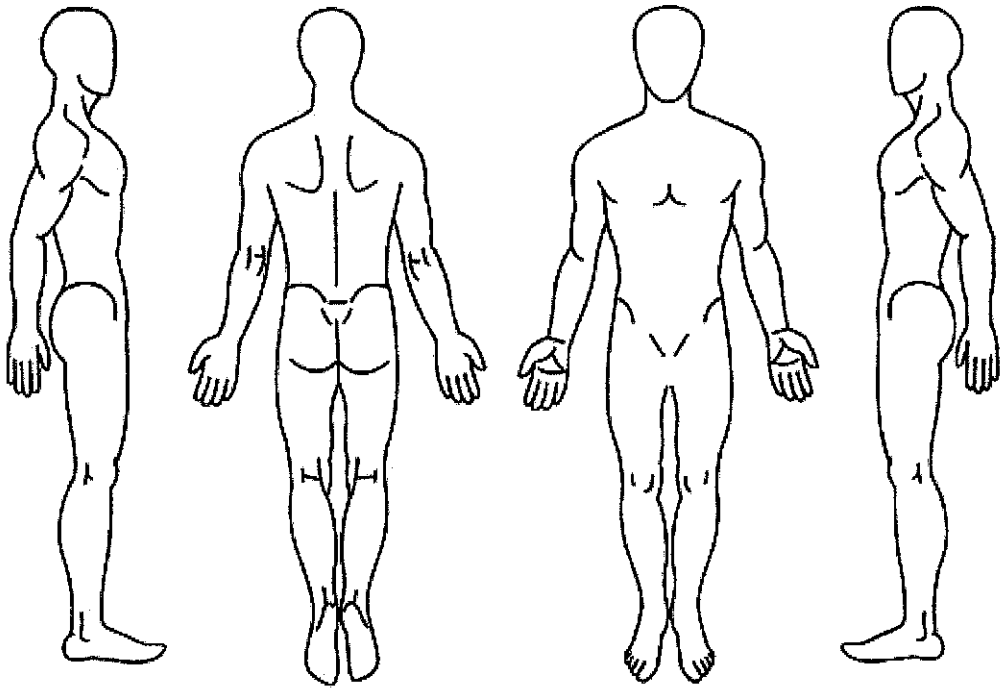
Other:

_____

Please Outline Areas of Discomfort

A – Aching B – Burning C – Cold R – Radiating

H – Hypersensitivity N – Numbness S – Stabbing T – Tingling



Symptom Checklist

For the following symptoms, please select a corresponding number to indicate the severity of your symptoms. If you have a symptom that is not listed – please add it at the bottom and rate it according to the scale below.

0 = None	1-2 = Mild	3-4 = Moderate	5-6 = Severe
Headaches	0 1 2 3 4 5 6	Don't "Feel Right"	0 1 2 3 4 5 6
Pressure in Head	0 1 2 3 4 5 6	Difficulty Concentrating	0 1 2 3 4 5 6
Neck Pain	0 1 2 3 4 5 6	Difficulty Remembering	0 1 2 3 4 5 6
Nausea or Vomiting	0 1 2 3 4 5 6	Fatigue/Low Energy	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Confusion	0 1 2 3 4 5 6
Blurred Vision	0 1 2 3 4 5 6	Drowsiness	0 1 2 3 4 5 6
Balance Problems	0 1 2 3 4 5 6	Trouble Falling Asleep	0 1 2 3 4 5 6
Sensitivity to Light	0 1 2 3 4 5 6	More Emotional	0 1 2 3 4 5 6
Sensitivity to Noise	0 1 2 3 4 5 6	Irritable	0 1 2 3 4 5 6
Feeling Slowed Down	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Feeling in a Fog	0 1 2 3 4 5 6	Nervous or Anxious	0 1 2 3 4 5 6

Detailed History

Please answer all of the questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they are all important to help diagnose and formulate a plan of action specifically for you and make proper referrals. If needed, use the margins and back of paper to explain more details.

C = Current P = Past

Include dates if possible for both if longer than 6 months ago.

What Independent or Concurrent Therapies Have you Experienced:

_____ Chiropractic	_____Naturopathic	_____Specialist
_____Eastern Medicine	_____Natural Healer	_____Acupuncture
_____Nutritional Consult	_____Spiritual Healer	_____Massage
_____Medical Treatment	_____Energy Work	

What Diagnostic or Routine Exams Have you Experienced:

_____Xray	_____Upper/Lower GI	_____Dental Exam
_____MRI	_____DEXA Scan	_____Colonoscopy
_____CAT Scan	_____Breast Exam	_____Other:
_____Blood Draw	_____Prostate Exam	_____Other:
_____Ultrasound	_____Eye Exam	_____Other:

General Health: If time of day is a factor – please note

_____Poor Appetite
_____Heavy Appetite
_____Change in Appetite
_____Unexplained Weight Gain/Loss
_____Pins & Needles
_____Sweats Easily
_____Excessive Sweating
_____Body Odor Change
_____Stress
_____Bowel/Bladder Changes
_____Sudden waking at night
_____Day Napping
_____Night Sweats
_____Sudden Energy Drop
_____Poor Sleep
_____Wake Feeling Tired
_____Decreased Sleep
_____Heavy Sleep
_____Insomnia
_____Apnea/Narcolepsy
_____Hot/Cold
_____Night Pain
_____Radiating Pain
_____Numbness/Tingling
_____Strong Thirst
_____Fatigue
_____Chills
_____Sudden Temp Changes
_____Poor Circulation
_____Peculiar Tastes/Smells
_____Bleed/Bruise Easily (Where?)
_____Hours of Sleep at Night _____

Appliances or Aids

_____Glasses/Prisms
_____Contacts
_____Orthotics
_____Joint Replacement
_____Prosthetics
_____Implants of any kind
_____Braces
_____Splints
_____Pace Maker
_____Hearing Aids
_____Other:
_____Other:

Neuropsychological

_____Seizures
_____Depression
_____Anxiety
_____Poor Memory
_____Foggy Thinking
_____Bad Temper
_____Concussion
_____Easily Stressed
_____Considered/Attempted Suicide
_____Treated for Emotional Concerns
_____Antidepressant Meds
_____Other Neurological or Psychological Concerns

Lifestyle and Social History

Stress Screening: Y = Yes N = No

_____Can you relax when you want?
_____Have trouble dealing with stress?
_____Are you therapy or counseling?
_____Does it help?
_____Is your family safe to express true emotions?
_____Are romantic relationships fulfilling?
_____Does stress lead to digestive problems?
_____Do you abuse food/alcohol/tobacco to deal with unpleasant feelings?
_____Do you vent unpleasant emotions in a satisfying way?
_____Do you avoid conflicts at your expense?
_____Do you feel your health is out of your hands?
_____Have you tried to deal with stress, but couldn't succeed?
_____Do you feel capable of resolving your problems, but simply need to know how?
_____How much do you love yourself ? 0……100%

Do you find any dysfunction or concern in the following areas: Y = Yes N = No

_____Relationships with family	_____Hobbies	_____Childhood
_____Relationships with friends	_____Past Time Activities	_____Past Relationships
_____Social Skills	_____Intimate Relationships	_____Childhood Religious
_____Career	_____Sex	Teachings
_____Work	_____Religious Life	
_____Leisure	_____Spiritual Path	

Brain Function Assessment

0 – None/Never 1 – Mild/Occasional 2 – Frequent/Moderate 3 – Severe/Constant

Section 1: Brain Endurance				Difficulty finding words when speaking			
A decrease in attention span	**0**	**1**	**2**	**3**	Misplacement of things and inability to retrace steps	**0**	**1**	**2**	**3**
Mental Fatigue	**0**	**1**	**2**	**3**	Poor judgement and bad decisions	**0**	**1**	**2**	**3**
Difficulty learning new things	**0**	**1**	**2**	**3**	Disinterest in hobbies, social activities, or work	**0**	**1**	**2**	**3**
Difficulty staying focused and concentrating for extended periods of time	**0**	**1**	**2**	**3**	Personality or mood changes	**0**	**1**	**2**	**3**
Experiencing fatigue when reading sooner than in the past	**0**	**1**	**2**	**3**	**Section 4: Temporal Lobe**				
Experiencing fatigue when driving sooner than in the past	**0**	**1**	**2**	**3**	Reduced function in overall hearing	**0**	**1**	**2**	**3**
Need for caffeine to stay mentally alert	**0**	**1**	**2**	**3**	Difficulty understanding language with background or scatter noise	**0**	**1**	**2**	**3**
Section 2: Posture & Movement					Ringing or buzzing in the ear	**0**	**1**	**2**	**3**
Twitching or tremor in your hands and legs when resting	**0**	**1**	**2**	**3**	Difficulty comprehending language without perfect pronunciation	**0**	**1**	**2**	**3**
Handwriting has gotten smaller and more crowded together	**0**	**1**	**2**	**3**	Difficulty recognizing familiar faces	**0**	**1**	**2**	**3**
A loss of smell to foods	**0**	**1**	**2**	**3**	Changes in comprehending the meaning of sentences, written or spoken	**0**	**1**	**2**	**3**
Difficulty sleeping or fitful sleep	**0**	**1**	**2**	**3**	Difficulty with verbal memory and finding words	**0**	**1**	**2**	**3**
Stiffness in shoulders and hips that goes away when you start to move	**0**	**1**	**2**	**3**	Difficulty remembering events	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**	Difficulty recalling previously learned facts and names	**0**	**1**	**2**	**3**
Voice has become softer	**0**	**1**	**2**	**3**	Inability to comprehend familiar words when reading	**0**	**1**	**2**	**3**
Facial expression that is serious or angry	**0**	**1**	**2**	**3**	Difficulty spelling familiar words	**0**	**1**	**2**	**3**
Episodes of dizziness or light-headedness upon standing	**0**	**1**	**2**	**3**	Monotone, unemotional speech	**0**	**1**	**2**	**3**
A hunched over posture when getting up and walking	**0**	**1**	**2**	**3**	Difficulty understanding the emotions of others when the speak (nonverbal cues)	**0**	**1**	**2**	**3**
Section 3: Memory and Cognition					Disinterest in music and a lack of appreciation for melodies	**0**	**1**	**2**	**3**
Memory loss that impacts daily activities	**0**	**1**	**2**	**3**	Difficulty with long-term memory	**0**	**1**	**2**	**3**
Difficulty planning, problem solving, or working with numbers	**0**	**1**	**2**	**3**	Memory impairment when doing basic activities of daily living	**0**	**1**	**2**	**3**
Confusion about dates, the passage of time, or place	**0**	**1**	**2**	**3**	Difficulty with directions and visual memory	**0**	**1**	**2**	**3**
Difficulty understanding visual images and special relationships (addresses & locations)	**0**	**1**	**2**	**3**	Noticeable differences in energy levels throughout the day	**0**	**1**	**2**	**3**

Section 5: Occipital Lobe

Difficulty coordinating visual input and hand movements, resulting in an inability to efficiently reach for objects	**0 1 2 3**	Bloating after meals	**0 1 2 3**
Difficulty comprehending written text	**0 1 2 3**	Dry eyes/mouth	**0 1 2 3**
Floaters or halos in your visual field	**0 1 2 3**	A racing heart	**0 1 2 3**
Dullness of colors in your visual field during different times of day	**0 1 2 3**	A flutter in the chest or an abnormal heart rhythm	**0 1 2 3**
Difficulty discriminating similar shades of color	**0 1 2 3**	Bowl or bladder incontinence, resulting in staining your underwear	**0 1 2 3**
Section 6: Frontal Cortex		**Section 9: Basal Ganglia Direct Pathway**	
Difficulty with detailed hand coordination	**0 1 2 3**	Decrease in movement speed	**0 1 2 3**
Difficulty with making decisions	**0 1 2 3**	Difficulty initiating movement	**0 1 2 3**
Difficulty suppressing socially inappropriate thoughts	**0 1 2 3**	Stiffness in your muscles (not joints)	**0 1 2 3**
Socially inappropriate behavior	**0 1 2 3**	A stooped posture when walking	**0 1 2 3**
Decisions made based on desires, regardless of the consequences	**0 1 2 3**	Cramping of your hand when writing	**0 1 2 3**
Difficulty planning and organizing daily events	**0 1 2 3**	**Section 10: Basal Ganglia Indirect Pathway**	
Difficulty motivating yourself to start and finish tasks	**0 1 2 3**	Abnormal body movements (such as twitching legs)	**0 1 2 3**
A loss of attention and concentration	**0 1 2 3**	Desires to flinch, clear your throat, or perform some type of movement	**0 1 2 3**
Section 7: Parietal Lobe		Constant nervousness and restless mind	**0 1 2 3**
Hypersensitivities to touch or pain	**0 1 2 3**	Compulsive behaviors	**0 1 2 3**
Difficulty with spatial awareness when moving, laying back in a chair or leaning against a wall	**0 1 2 3**	Increased tightness and tone in specific muscles	**0 1 2 3**
Frequently bumping into the wall or objects	**0 1 2 3**	**Section 11: Cerebellum**	
Difficulty with right-left discrimination	**0 1 2 3**	Difficulty with balance, or balance that is noticeably worse on one side	**0 1 2 3**
Handwriting has become sloppier	**0 1 2 3**	A need to hold the handrail or watch each step carefully when going town stairs	**0 1 2 3**
Difficulty finding words for written or verbal communication	**0 1 2 3**	Episodes of dizziness	**0 1 2 3**
Difficulty recognizing symbols, words, or letters	**0 1 2 3**	Nausea, car sickness, or seasickness	**0 1 2 3**
Section 8: Pontomedullary Brainstem		A quick impact after consuming alcohol	**0 1 2 3**
Difficulty swallowing supplements or large bites of food	**0 1 2 3**	A slight hand shake when reaching for something	**0 1 2 3**
Bowel motility and movements slow	**0 1 2 3**	Back muscles that tire quickly when standing or walking	**0 1 2 3**
		Chronic neck or back muscle tightness	**0 1 2 3**

Detailed Description of your Symptoms

Please share a detailed description of your condition including each individual symptom or concern. This may include both physical and mental health, as well as acute and/or chronic conditions. You may want to address the following

- What is the frequency?
- Describe the pain/condition
- Where is it located?
- Does it change in presentation?
- What makes it better/worse?
- What tests have you had for each condition?
- What providers have you seen for the conditions/symptoms?
- Any other factors that may be associated

All of this can be in whatever format you prefer. Some patients prefer a narrative; others find a listing of events by year to be more concise and organized. Whatever composition style you choose is acceptable as long as it is concise and organized.

Account Authorization

I hereby give my authorization to treat me or my minor child as named herein on this form. Office policy requires payment in full for all services and goods rendered at the time of your visit to the office unless other arrangements have been made by the office manager. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable. I hereby authorize payment of any and all benefits, medical or otherwise, to the physician for the services and/or goods rendered. I further authorize the physician and/or suppler to release my information as required to process any and all insurance claims. I understand the above information in its entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. I also understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.

Patient Signature (Parent or Guardian Signature if Patient is a minor) **Date:**

_____ _____