Health by Hands CHIROPRACTIC

16645 W. Greenfield Ave. Suite D
New Berlin, WI 53151

Adult 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

Main Health Concern: _____

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 _____

Social History

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

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

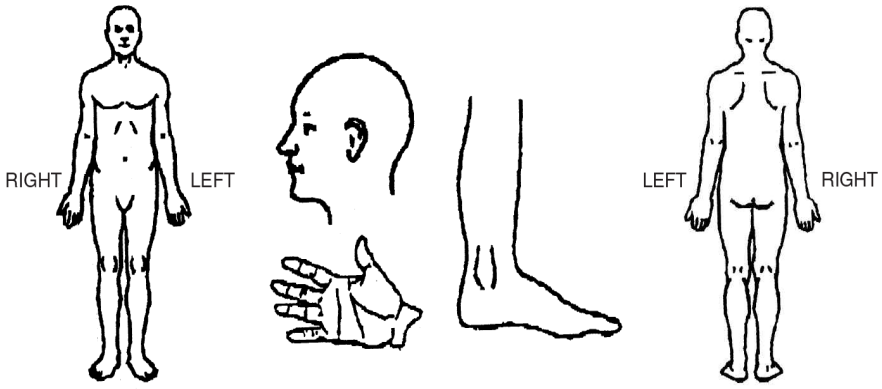
Number alcoholic beverages per week _____ Do you use recreational drugs? _____

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 pain 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:_____ How and when did the pain start?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 Have you experienced this before?_____

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:_____ How and when did the pain start?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 Have you experienced this before?_____

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. _____
