

431 E. Clairemont Ave.
Eau Claire, WI 54701
Phone: 715-832-2223 Fax: 715-832-7416

DATE: _____

Please fill out the following form in as much detail as possible

PERSONAL INFORMATION			
NAME		E-MAIL	
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE		WORK PHONE
D.O.B.	AGE	SEX <input type="checkbox"/> male <input type="checkbox"/> female	SS #:
EMPLOYER		OCCUPATION	
MARITAL STATUS (circle one): Married Single Widowed Divorced Separated			
SPOUSE'S NAME:			
CHILDREN (names and ages):			
Is any other member of your family being treated in this office? <input type="checkbox"/> Yes <input type="checkbox"/> No		Who referred you to this office?	
How did you hear about this office? <input type="checkbox"/> Leader-Telegram <input type="checkbox"/> Volume One <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Company <input type="checkbox"/> Friend/Family <input type="checkbox"/> Website _____ <input type="checkbox"/> Other _____			
Emergency Contact	Phone	Relationship	

CURRENT HEALTH	
Reason for visit/major complaints/concerns/symptoms (please be as specific as possible)	
How do you believe your problem/pain began? (please be as specific as possible)	
When did this condition begin?	Has this condition or a similar one occurred before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the condition affecting daily activities? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you lost work due to the condition? <input type="checkbox"/> Y <input type="checkbox"/> N
Rate the pain you are experiencing (no pain) 0 ♦ 1 ♦ 2 ♦ 3 ♦ 4 ♦ 5 ♦ 6 ♦ 7 ♦ 8 ♦ 9 ♦ 10 (most severe pain)	
Is the pain: <input type="checkbox"/> Constant <input type="checkbox"/> Nearly Constant <input type="checkbox"/> Occasional <input type="checkbox"/> Comes & Goes <input type="checkbox"/> Other _____	
Is the pain worse: <input type="checkbox"/> In the AM <input type="checkbox"/> In the PM <input type="checkbox"/> At work <input type="checkbox"/> At rest <input type="checkbox"/> Other _____	
What makes the pain worse?	
What makes the pain better?	
Is the condition: <input type="checkbox"/> Job related <input type="checkbox"/> Auto Accident <input type="checkbox"/> Home injury <input type="checkbox"/> Fall <input type="checkbox"/> Other _____	
Date of Accident	Have you reported the accident to your employer? <input type="checkbox"/> Yes <input type="checkbox"/> NO <input type="checkbox"/> N/A
Current prescriptions or over-the-counter medications/Vitamins/Herbs:	
Are you allergic to anything you are aware of? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	
Previous Chiropractic Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Doctor's name & location:	Approximate date of last visit:
Have you seen other doctors for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list:	

PAST HEALTH HISTORY

Have you had X-ray/MRI taken in the past two years? Yes No if yes, where _____

Past Injuries/Surgeries Can Affect Current Health (please be specific)

Have you had any operations/surgeries? Yes No

Appendix Tonsils Gall bladder Hernia Neck/back surgery C-section Heart Hysterectomy

Cosmetic Joint Replacement Other _____

Past Accidents or Injuries None Auto Accident Sports Injury Work Related Fall on ice

Fall from height Concussion/Uncnscious Head injury Broken bones Dislocations Other

Describe the Checked Above:

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAVE HAD:

- Pneumonia Anemia Chicken Pox Kidney Disease Epilepsy
- Rheumatic Fever Measles Diabetes Thyroid Mental Disorders
- Polio Mumps Cancer Pleurisy Migraine Headaches
- Tuberculosis Small Pox Heart Disease Arthritis High Blood Pressure
- Whooping Cough AIDS/HIV Liver Disease High Cholesterol Osteoporosis
- Glaucoma Colitis/Crohn's Heart Attack Emphysema Seizure-Convulsions
- Asthma Ulcer Stroke Circulation Problems Lymes Disease

Do you have any health problems not listed above?

FEMALES

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? Yes No

Are you breast feeding/lactating? Yes No

SOCIAL HISTORY

HABITS: Smoking _____ packs/day Alcohol _____ drinks/wk Coffee/Caffeine _____ cups/day
 Water _____ cups/day High Stress (reason) _____

SLEEP: Hours per day _____ # of pillows _____ Difficulty sleeping Y N Reason _____

Sleep position: Back Side Stomach Varies

EXERCISE: none some lots! # days/week _____

Type of exercise: bike walk run weights swim other _____

HOBBIES: (please list) _____

WORK ACTIVITY

YEARS AT CURRENT JOB: _____

USUAL JOB TASKS: Standing Sitting Walking Bending Stooping Twisting Crawling
 Computer Work Lifting Driving Operating Equipment Light Labor Heavy Labor

FAMILY HEALTH HISTORY

Please check and indicate family members that have/had the condition (include: mother, father, sibling, spouse, child, & grandparent.

Heart Disease _____ Stroke _____ Cancer _____

Diabetes _____ Lung Disease _____ High Blood Pressure _____

Other _____

The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Patient Signature: _____ **Date:** _____

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Patient Name: _____ **Today's Date:** _____ **D.O.B:** _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please circle the letter **N** if you have these conditions now (within the past 6 months) or **P** if you ever had these conditions in the past. Do **NOT** circle either if you have **NOT** experienced the symptom.

MUSCULO-SKELETAL

- N P Low Back Pain
- N P Pain between shoulders
- N P Neck Pain
- N P Arm Pain
- N P Joint Pain/Stiffness
- N P Walking Problems
- N P Difficulty Chewing
- N P Clicking Jaw
- N P General Stiffness

GASTRO-INTESTINAL

- N P Poor/Excessive Appetite
- N P Excessive Thirst
- N P Frequent Nausea
- N P Vomiting
- N P Diarrhea
- N P Constipation
- N P Hemorrhoids
- N P Liver Problems
- N P Gall Bladder Problems
- N P Weight Trouble
- N P Abdominal Cramps
- N P Gas/Bloating After Meals
- N P Heart Burn
- N P Black/Bloody Stool
- N P Colitis

C-V-R

- N P Chest pain
- N P Short breath
- N P Blood Pressure Problems
- N P Irregular Heartbeat
- N P Heart Problems
- N P Lung Problem/Congestion
- N P Varicose Veins
- N P Ankle Swelling
- N P Stroke

GENERAL

- N P Fatigue
- N P Allergies
- N P Loss of sleep
- N P Fever
- N P Headache

NERVOUS SYSTEM

- N P Nervous
- N P Numbness
- N P Paralysis
- N P Dizziness
- N P Forgetfulness
- N P Confusion/Depression
- N P Fainting
- N P Convulsions
- N P Cold/Tingling Extremities
- N P Stress

NERVOUS SYSTEM

- N P Bladder Trouble
- N P Painful/Excessive Urination
- N P Discolored Urine

EENT

- N P Vision Problems
- N P Dental Problems
- N P Sore Throat
- N P Ear Aches
- N P Hearing Difficulties
- N P Stuffed Nose

MALES ONLY

- N P Prostate Problem
- N P Sexual Dysfunction

FEMALES ONLY

- N P Vaginal Pain/infection
- N P Breast Pain/lumps
- N P Menstrual Cramps
- N P Menstrual Irregularities

PLEASE MARK ON THE DIAGRAM the area(s) of your discomfort and indicate the quality of pain being experienced with the corresponding letters.

(If you need assistance, please ask!)

SSS = Sharp DDD = dull AAA = achy TTT = tight
NNN = numb/tingle BBB = burn OOO = shooting ZZZ = stabbing

PLEASE RATE BELOW THE INTENSITY OF YOUR DISCOMFORT

Neck-Shoulder-Arm

On a scale of zero to 10, I rate my pain/discomfort as follows;

0 ----- 10

0= no pain
 5= moderate pain w/o activity restriction
 10= severe pain, with activity restriction and inability to go without awareness of pain

Mid-back Pain

On a scale of zero to 10, I rate my pain/discomfort as follows;

0 ----- 10

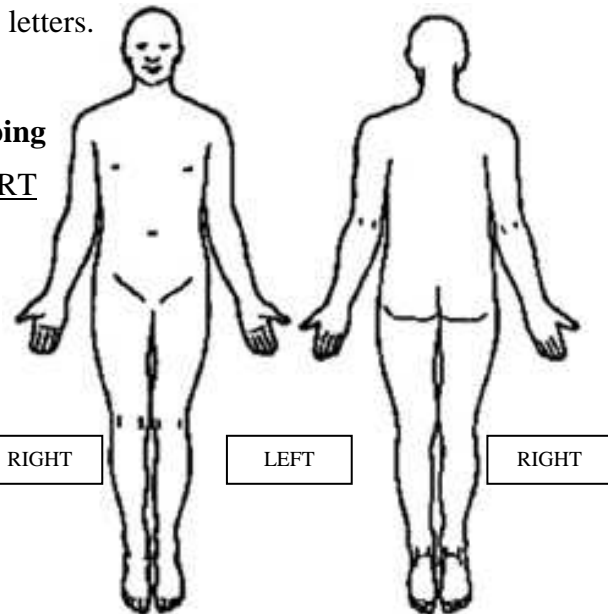
0= no pain
 5= moderate pain w/o activity restriction
 10= severe pain, with activity restriction and inability to go without awareness of pain

Low back & Leg pain

On a scale of zero to 10, I rate my pain/discomfort as follows;

0 ----- 10

0= no pain
 5= moderate pain w/o activity restriction
 10= severe pain, with activity restriction and inability to go without awareness of pain



Patient Signature: _____ **Date:** _____