CHIROPRACTIC CARE CENTER ~ FRANKLIN

9735 W. St. Martins Rd. (Hwy 100 & Loomis Rd.) Franklin, WI 53132 ~ 414-525-9895

CONFIDENTIAL PATIENT HEALTH HISTORY FORM

Name _____ Today's Date _____

Address _____City/State_____ Zip _____

Home Phone (_____)_____ Work Phone (_____) _____ Cell Phone (____)_____

Email Address _____

Please circle your contact preference: Phone E-mail Text (If text, Cell Carrier:_____)

Age _____ Birth Date _____/_____/_____ Sex: M / F Height _____ Weight _____

S.S. # _____-_____-_____ Marital Status (Please circle): Single Married Partnered Divorced Widowed

Race/Ethnicity (Please circle): Caucasian African American Hispanic American Indian/Alaska Native

Asian/Pacific Islander Other_____

Primary language _____ Secondary language _____

Do you have any children? If yes, please list names and ages_____

Contact in Case of Emergency _____ Phone # (_____) _____

How did you find out about our office? (Please be specific)_____

What are your chief complaints?_ _____

When did these complaints begin? (Date) _____

What caused these problems? _____

Complaints/Disturbances: ☐ Come and go ☐ Came on gradually ☐ Came on suddenly

Symptoms are BETTER in: ☐ A.M. ☐ P.M. 6) Symptoms are WORSE in: ☐ A.M. ☐ P.M.

Symptoms have persisted for: ☐ hours ☐ 1-day ☐ days ☐ weeks ☐ months ☐ years

Symptoms developed from: ☐ a work injury ☐ an auto accident ☐ other accident

Explain what happened: _____

Have you ever been in a Motor Vehicle Accident? If yes, please describe_____

Describe other complaints. Please be specific:

Involving neck and head: _____

Involving mid-back/shoulders/arms & hands: _____

Involving low back/hips/legs & feet: _____

What activities make conditions WORSE? _____

What activities make conditions BETTER? _____

Have you ever had this condition/problem before? ☐ Yes ☐ No When? _____

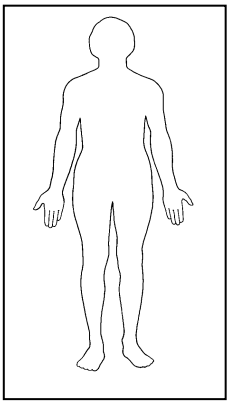
What other treatments have you tried? (Please circle): Massage Physical Therapy Chiropractic
Medicine (Rx/OTC) Cortisone Surgery Other (Explain) _____

Shade and code areas to indicate location of pain or discomfort:

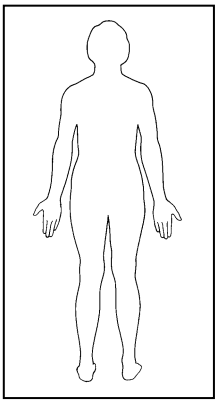
Use Codes:

Numbness	- - - - - - - - -
Pins & Needles	+ + + + + +
Burning	X X X X X X
Dull Ache	o o o o o o
Stabbing Pain	/ / / / / / / / /

FRONT



BACK



Indicate ability to perform the following activities: use codes: U = unable P = painful L = limited N = normal

_____ coughing	_____ lying on back	_____ kneeling
_____ sneezing	_____ lying flat on stomach	_____ stooping
_____ bending forward	_____ lying on side with knees bent	_____ gripping
_____ climbing stairs	_____ turning over in bed	_____ pushing
_____ walking short distances	_____ sleeping	_____ pulling
_____ standing more than one-hour	_____ balancing	_____ reaching
_____ sitting at a table	_____ dressing self	_____ sexual activity

Check any of the following diseases you have had:

☐AIDS	☐Chicken Pox	☐Fractures	☐Liver Disease	☐Pneumonia
☐Alcoholism	☐Diabetes	☐Gall Stones	☐Measles	☐Psoriasis
☐Anemia	☐Eating Disorder	☐Heart Disease	☐Mental Disorder	☐Scoliosis
☐Appendicitis	☐Eczema	☐Influenza	☐Multiple Sclerosis	☐Stroke
☐Arthritis	☐Epilepsy/Seizures	☐Irritable Bowel Synd.	☐Osteoporosis/penia	☐Thyroid Disorder
☐Cancer	☐Fibromyalgia	☐Kidney Stones	☐Pleurisy	☐Tuberculosis

Check any of the following problems you have or have had in the past 6 months

Muscles & Joints
☐Low Back Pain
☐Pain Between Shoulders/ Mid-Back Pain
☐Neck Pain/Stiffness
☐Arm/Elbow/Wrist Pain
☐Walking Problems
☐Difficulty Chewing
☐Clicking Jaw
☐Leg/Knee/Foot Pain
☐Hip Pain
☐Pain in Tailbone

Eye, Ear, Nose & Throat
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Earaches
☐Hearing Difficulty
☐Stuffed Nose
☐Ringing in Ears
☐Nose Bleeds
☐Sinus Trouble
☐Swollen Glands
☐Frequent Colds

General Problems
☐Fatigue
☐Night Sweats
☐Loss of Sleep
☐Fever
☐Headaches
☐Weakness
☐Migraines

Hearts & Lungs
☐Wheezing/Bronchitis
☐Chest Pain
☐Asthma
☐Short Breath
☐High Blood Pressure
☐Low Blood Pressure
☐Irregular Heart Beat
☐Heart Surgery
☐Lung Congestion
☐Coughing
☐Spitting Blood
☐Varicose Veins
☐Ankle Swelling

Stomach/Intestines
☐Poor Appetite
☐Excessive Appetite
☐Excessive Thirst
☐Nausea
☐Vomiting
☐Poor Digestion
☐Hemorrhoids/Piles
☐Liver Trouble
☐Gall Bladder
☐Weight Trouble
☐Stomach Cramps
☐Stomach Pain
☐Gas/Bloating
☐Heartburn
☐Black/Bloody Stool
☐Colitis
☐Diarrhea
☐Constipation

Kidney/Bladder
☐Painful Urination
☐Excessive Urine
☐Discolored Urine
☐Bedwetting
☐Bad Urine Control

Nervous System
☐Nervousness
☐Numbness
☐Paralysis
☐Dizziness
☐Confusion
☐Depression
☐Fainting
☐Convulsions/Seizures
☐Cold Extremities

Women
☐Menses Irregular
☐Menstrual Cramps
☐Vaginal Pain
☐Breast Lumps
☐Pain During Sex
☐Infertility
☐Miscarriage

Men
☐Prostate Pain
☐Impotence
☐Infertility

PLEASE USE THE BACK OF THIS SHEET IF YOU NEED TO ADD ADDITIONAL INFORMATION

Please list any medications that you are currently taking and what they are for (include any prescription medicine that you take as well as "over the counter" medications, vitamins and pain relievers.)

Name of Medication **Reason?** **Date started?** **Strength?** **Dosage?** **Frequency?**

Do you have any allergies?

Name of Allergy **Type of Allergy** **Reaction to allergen?** **Adverse event date?**

Have you had any surgeries?

Type of surgery **Date of surgery** **Surgeon's name?** **Result of surgery?**

Have you had any Hospitalizations?

Date of hospitalization **Reason for hospitalization** **Name of hospital**

Have you had or do you have now any Major Illnesses?

Name of the Illness **Date of Illness**

Have you been Immunized?

Date of vaccine **Name of vaccine** **Reaction to vaccine** **Site of vaccine given**

Have you had any tests performed?

Date of test **Name of test** **Results from test**

Family History:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE	HIGH B.P.	DECEASED
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐

If deceased, please list the cause: _____

Women: Are you pregnant? Yes No Unsure/Possibly

What was the first day of your last menstrual cycle? (Date)_____

Social History:

Habits: ☐ Smoking - How much? _____ ☐ Alcohol - How much? _____

☐ Caffeine - How much? _____ ☐ Drug Use - How much? _____

What recreational or exercise activities are you involved in? _____

_____

Occupational History:

Company or Employer name? _____

Start Date: _____ End date: _____

Occupation: _____ Status: _____

What type of activities do you do at work? _____

_____

Physician History:

Have you ever been treated by a chiropractor?_____ If yes, Doctor Name and Date_____

Do you have a medical doctor? ____ If yes, Doctor's name, date of last visit and location _____

_____

Purpose of that visit? _____ Last X-Rays from any doctor (Date)_____

PAYMENT INFORMATION

Please give any insurance information you may have and a copy of your insurance card to our Front Desk Assistant. We will be happy to determine coverage for you. Clinic policy requires that payment arrangements be made on the first visit if any balance is due. Our overall corporate policy is that finances do not become a barrier for you to get the care you need. Please indicate below how you will be taking care of this account:

☐ Health Insurance ☐ Cash/Check/Credit Card ☐ Auto Insurance

☐ Medicare ☐ Medicaid/Title 19/Badger Care ☐ Worker's Compensation

CONSENT TO TREAT

The primary treatment used by doctors of Chiropractic is the spinal adjustment. We will use primarily that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust, your joints. By signing below you state that you are willing to undergo a chiropractic examination, x-rays of your spine (if indicated) and chiropractic treatment as outlined by the doctor. If any x-rays are taken they will remain the property of this office. The payment to the office for the x-rays is for the x-ray films and the examination of the x-rays. I understand and agree that I am personally responsible for payment of all fees charged by this office. Returned checks will be subject to a $30 service fee. I hereby authorize assignment of my insurance and benefits (if applicable to the provider for services rendered).

Signature _____ Date _____

Consent to treat a minor child _____ Relation _____

CHIROPRACTIC CARE CENTER ~ FRANKLIN

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTIONAL TEST"

Patient Name_____Date:_____

Instructions: Please circle the correct response. Sign and date when completed.

Have you ever been diagnosed with or told you had any of the following?

1. High blood pressure (hypertension)? ..... Yes/No
2. Hardening of the arteries (arteriosclerosis)? ..... Yes/No
3. Diabetes? ..... Yes/No
4. Heart or blood vessel disease? ..... Yes/No
5. Bones spurs on the neck bones (cervical spondylosis)? ..... Yes/No
6. Whiplash injury (flexion-extension injury) (cervical sprain)? ..... Yes/No
7. Have any of your relatives ever suffered a stroke? ..... Yes/No
8. Were you ever a smoker? From_____to_____ ..... Yes/No
9. Do you take any medication on regular basis? ..... Yes/No
10. (Women only) Have you ever used prescription birth control? ..... Yes/No

Have you ever experienced any of the following, even short temporary attacks?

11. Blurred vision? ..... Yes/No
12. Double vision? ..... Yes/No
13. Diminished or partial loss of vision in one or both eyes? ..... Yes/No
14. Complete loss of vision in one or both eyes? ..... Yes/No
15. Ringing, buzzing, or any noise in the ear(s)? ..... Yes/No
16. Hearing loss in one or both ears? ..... Yes/No
17. Slurred speech or other speech problems? ..... Yes/No
18. Difficulty swallowing? ..... Yes/No
19. Dizziness? ..... Yes/No
20. Temporary lack of understanding? ..... Yes/No
21. Loss of consciousness, even momentary blackouts? ..... Yes/No
22. Numbness or loss of sensation in the face, fingers, hands, arms, legs, or other parts of the body? ..... Yes/No
23. Any other abnormal sensations in any part of body? ..... Yes/No
24. Weakness, clumsiness or loss of strength in face, fingers, hands, arms, or legs? ..... Yes/No
25. Sudden collapse without loss of consciousness? ..... Yes/No

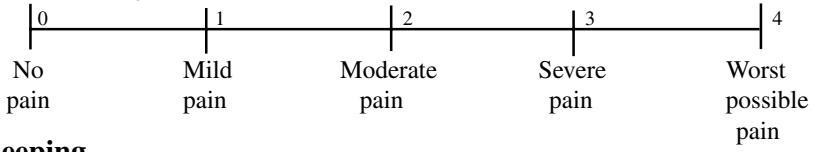
Patient Signature_____ Date_____

Functional Rating Index

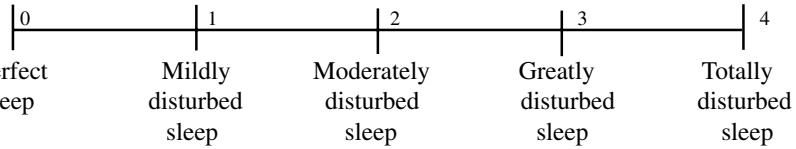
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

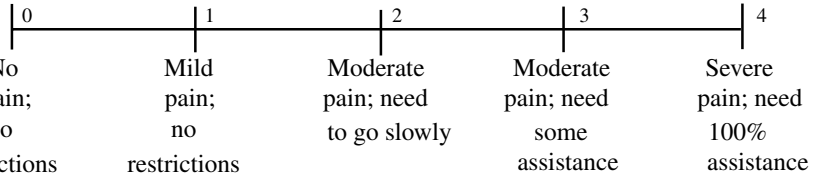
1. Pain Intensity



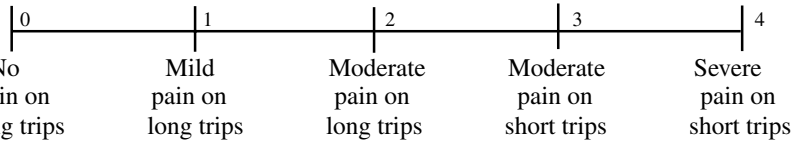
2. Sleeping



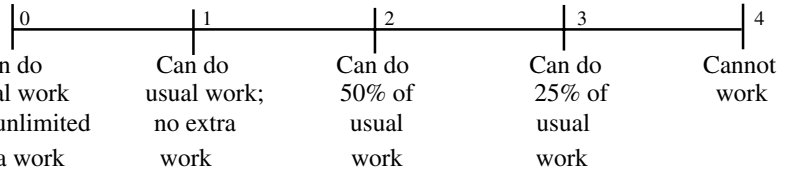
3. Personal Care (washing, dressing, etc.)



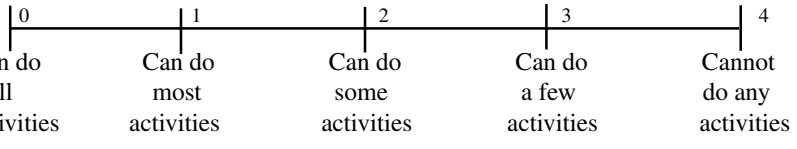
4. Travel (driving, etc.)



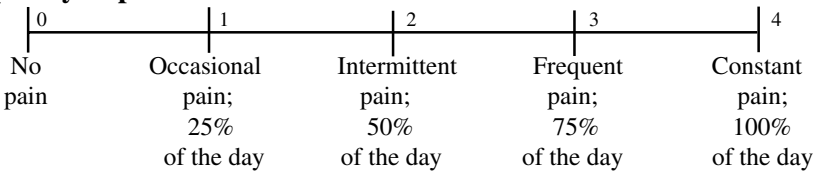
5. Work



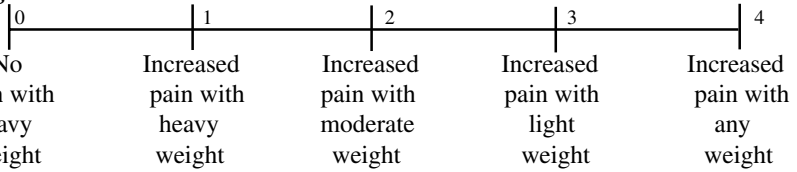
6. Recreation



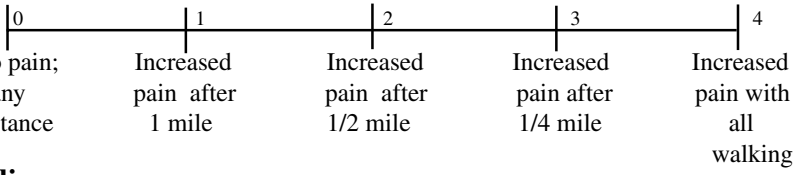
7. Frequency of pain



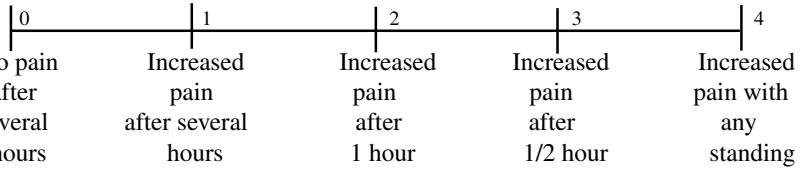
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date