Patient Health History

☐ New Patient
☐ Reactivate (1 year)

JOINT & SPINE

2327 Neva Road
Antigo, WI 54409

Today's Date: _____

Personal Information

Name:	Home Phone:
Street Address:	Work Phone:
City/State/Zip:	Cell Phone:
Social Security #:	Date of Birth:
Driver's License #:	Email:
Emergency Contact:	Emergency Contact's Phone:

Status: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other: _____ ☐ Student: ☐ Full-Time ☐ Part-Time

Spouse's Name: _____ Insurance Subscriber's Name: _____

Spouse's D.O.B.: _____ Subscriber's D.O.B.: _____

How Did You Hear About Us? Check All That Apply: ☐ Referred By (Name): _____

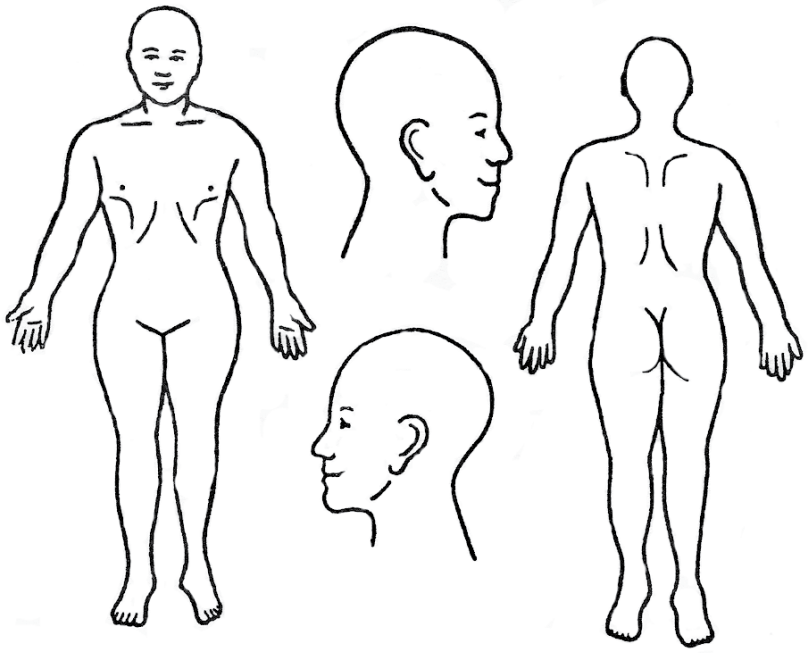
☐ Prior Patient ☐ Friend Of Dr./Staff ☐ Internet ☐ TV Ad ☐ Radio Ad ☐ Newspaper Ad ☐ Yellow Pages

☐ Sign/Location ☐ Event/Presentation: _____ ☐ Other: _____

Symptoms Developed From: Work-Related Injury Auto Accident Other _____

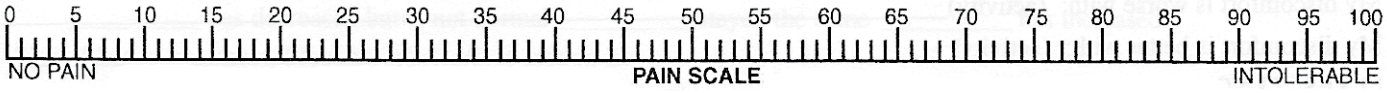
Be sure to fill out this section as accurately as possible. Mark the area with the described sensation, using the appropriate symbols.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)



Please rate your pain using the scale below:

If there is more than one area of discomfort, please rate the pain on a scale of 0 to 100 next to each area, with 0 being no pain and 100 being intolerable pain.



Please answer the first four questions below using a pain scale of 0-100 with 0 being no pain and 100 being the worst pain.

1. What is your pain level now? _____
2. What is your pain level most of the time? _____
3. What is your pain level at its best? _____
4. What is your pain level at its worst? _____

5. How often are you at a zero pain level?
   a. At least once a day
   b. Once a week
   c. Once every other week
   d. Once a month
   e. More than once a week
   f. Other _____

- ☐ I stay at home most of the time because of the pain.
- ☐ I change position frequently to try to decrease my pain.
- ☐ I walk more slowly than usual because of the pain.
- ☐ Because of my pain, I am not doing any jobs that I usually do around the house.
- ☐ Because of my pain, I use a handrail to get upstairs.
- ☐ Because of my pain, I lie down to rest more often.
- ☐ Because of my pain, I have to hold on to something to get out of an easy chair.
- ☐ Because of my pain, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my pain.
- ☐ I only stand up for short periods of time because of my pain.
- ☐ Because of the pain, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of the pain.
- ☐ I have pain almost all of the time.
- ☐ I find it difficult to turn over in bed because of the pain.
- ☐ My appetite is not very good because of the pain.
- ☐ I have trouble putting on my sock (stockings) because of the pain.
- ☐ I can only walk short distances because of the pain.
- ☐ I sleep less well because of the pain.
- ☐ Because of the pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of the pain.
- ☐ I avoid heavy jobs around the house because of the pain.
- ☐ Because of the pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of the pain, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of the pain.

Have you had any problems with the following areas? (Please mark Y for Yes or N for No in each of the following:)

☐ Eyes	☐ Urinary	☐ Internal Organs
☐ Ears, Nose, Mouth, Throat	☐ Muscles	☐ Blood
☐ Heart	☐ Nerves	☐ Allergies
☐ Lungs/Breathing	☐ Skin	☐ Other _____
☐ Intestines	☐ Psychological	_____

Please Describe for Yes Responses: _____

_____

_____

Past Medical History

☐ Yes ☐ No Allergies? To what?

☐ Yes ☐ No Do you now take prescription drugs, over-the-counter drugs, vitamins, or supplements?

Product/Drug	Reason	Frequency	Dosage	Helping?
1.				
2.				
3.				

☐ Yes ☐ No Have you ever had major illnesses, injuries, falls, hospitalizations, auto accidents, or surgeries?

Date	Dr. Name	Condition	Results	
1.			☐ Complete Recovery	☐ Complications
2.			☐ Complete Recovery	☐ Complications
3.			☐ Complete Recovery	☐ Complications

Family Health History

Select below medical conditions of your blood relatives (mother, father, brothers, sisters, children)

- ☐ Cardiovascular Disease (heart disease) Who _____
- ☐ Diabetes Who _____
- ☐ Cancer - Type _____ Who _____
- ☐ Arthritis Who _____

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

patient signature: _____ Date: _____

parent/guardian/legal representative signature: _____ Date: _____

d.c./c.a. signature: _____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care. This will allow you to be fully informed when consenting to treatment prior to initiating care.

Chiropractic offices use trained personnel to assist with portions of your consultation, examination, X-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

Specific Risk Possibilities Associated with Chiropractic Care:

Stroke - Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation. If it occurs, it may cause temporary or permanent brain dysfunction. On extremely rare occasions, death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical spine treatment poses a small risk. The chances of this occurring are estimated at 1 in 400,000 treatments to 1 in 5.8 million treatments (CMAJ 2001, Oct 2; 165 (7):905-6). The annual incidence of a spontaneous stroke is estimated at 1 to 1.5 per 100,000 (NEJM, 1994; 330:339-397). *This means that the chances of a spontaneous stroke are much higher than the chance of a stroke following a chiropractic adjustment.* The results of a retrospective study conducted by Haldeman S, et.al., suggested that stroke should be considered a random and unpredictable complication of any neck movement, including cervical manipulation (J.Neurol, 2002, Aug: 249(8): 1098-104).

Soreness - Chiropractic adjustments and physical therapy procedures may be accompanied by post-treatment soreness. This is a normal and acceptable response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience any soreness or discomfort.

Soft Tissue Injury - Occasionally, chiropractic treatment may aggravate a disc injury. It may also cause other minor joint, ligament, tendon, or soft tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment X-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Doctor of Chiropractic or staff if they occur.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal. If the results are not acceptable, we will refer you to another provider.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you fully understand, please print your name, sign, and date below, signifying informed consent for the treatment.

CONSENT TO TREAT A MINOR:

Having carefully read the above, I hereby give my informed consent to have the doctors and/or staff of this clinic examine, X-ray, and administer chiropractic care to my child as deemed necessary, in my presence or in my absence.

Patient's Name Printed

Today's Date

Patient's Signature

Parent or Guardian Signature for Minor