

# ABOUT THE PATIENT

Simply Health Chiropractic E5028 US Highway 14, Spring Green, WI 53588

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender ☐ M ☐ F  
 Significant Other's Name \_\_\_\_\_ Kid's Names and Ages \_\_\_\_\_  
 Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before? ☐ No ☐ Yes  
 Preferred way of receiving contact: ☐ Phone Call ☐ Email ☐ Text ☐ Other \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ ph # \_\_\_\_\_  
 Name of Medical Doctor(s) \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

Patient / Parent Signature \_\_\_\_\_

(This represents a long term authorization for all occasions of service)

Date \_\_\_\_\_

## REASON FOR SEEKING CARE

### PRESENT COMPLAINTS

1. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse  
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_
2. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse  
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_
3. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse  
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_
4. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse  
☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

8. What Doctor's have you seen for this? \_\_\_\_\_

9. Type of treatment: \_\_\_\_\_

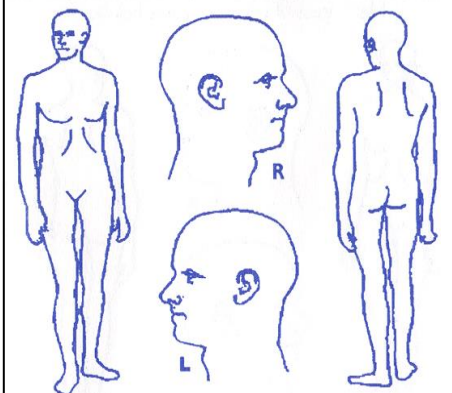
10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_

Are you pregnant?

☐ Yes ☐ No

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

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Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

## Past Present

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Shortness of Breath
- ☐ ☐ Allergies / Asthma
- ☐ ☐ Medication Side Effects
- ☐ ☐ Diabetes
- ☐ ☐ Hands or Feet cold
- ☐ ☐ Muscle aches
- ☐ ☐ Trouble Walking
- ☐ ☐ Leg / Foot Numbness
- ☐ ☐ Fainting
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Ringing in Ears
- ☐ ☐ Ear Problems
- ☐ ☐ Sleeping Problems
- ☐ ☐ Vision Problems
- ☐ ☐ Thyroid Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Kidney Problems
- ☐ ☐ Light Bothers Eyes
- ☐ ☐ Other \_\_\_\_\_

## Past Present

- ☐ ☐ Urinary Problems
- ☐ ☐ Easy Bruising
- ☐ ☐ Tobacco Use
- ☐ ☐ Dental Problems
- ☐ ☐ Fibromyalgia
- ☐ ☐ Blood Thinner use
- ☐ ☐ HIV Positive
- ☐ ☐ Cancer
- ☐ ☐ Depression
- ☐ ☐ Alcohol Use
- ☐ ☐ \_\_\_High or \_\_\_Low Blood Pressure
- ☐ ☐ Stroke History
- ☐ ☐ High Cholesterol
- ☐ ☐ TMJ
- ☐ ☐ Digestive Problems
- ☐ ☐ Pain all Over
- ☐ ☐ Tension / Irritability
- ☐ ☐ Chest Pains
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Heart Problems

1. List any medications you are taking: \_\_\_\_\_

2. Please list all doctors you are currently seeing: \_\_\_\_\_

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": ☐ No ☐ Yes, Name \_\_\_\_\_

## PAST HISTORY

4. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_

5. List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_

6. List any past sport, recreational, or home injuries \_\_\_\_\_

7. Please describe any past conditions and treatment received: \_\_\_\_\_

8. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other \_\_\_\_\_

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other \_\_\_\_\_

Is there any other family history you want us to know? \_\_\_\_\_

# STRESSORS

Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, sports, etc)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

2. Bio-Chemical Stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, alcohol, etc)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

3. Psychological or Mental-Emotional Stress (work, relationships, finances, self-esteem, etc)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

On a scale of 1-10, please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work: \_\_\_\_\_ At home: \_\_\_\_\_ At play: \_\_\_\_\_

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating Habits: \_\_\_\_\_ Exercise Habits: \_\_\_\_\_ Sleep: \_\_\_\_\_ General Health: \_\_\_\_\_ Mind Set: \_\_\_\_\_

How do you grade your Physical Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

How do you grade your Emotional / Mental Health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Getting Better ☐ Getting Worse

Is there anything else which may help us better understand you which has not been discussed?

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Why are you here at this point in time and what are you hoping our office can do for you?

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I consent to a professional and complete chiropractic examination and to any radiographic examination the doctor deems necessary.  
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_