

PATIENT PERSONAL INFORMATION

WELCOME TO DELAFIELD CHIROPRACTIC, IF YOU SHOULD NEED ANY ASSISTANCE IN COMPLETING THIS PAPER WORK PLEASE FEEL FREE TO ASK.

PATIENT ID #

DATE

1	PATIENT NAME			
last name		first	m.i.	nick name
street address				
city		state	zip code	
home#()		work # ()		ext
cell # ()		e-mail		

2	PATIENT PERSONAL INFO			
age	birthdate	SS#	sex <input type="radio"/> M <input type="radio"/> F	
status <input type="radio"/> single <input type="radio"/> married <input type="radio"/> widowed <input type="radio"/> separated <input type="radio"/> divorced				

3	SPOUSE OR GUARDIAN			
last name		first	m.i.	
SS#	birthdate	cell #()		
employer name		work # ()		

4	EMERGENCY CONTACT			
name		relationship		
home#()	work#()	cell#()		

5	PATIENT EMPLOYMENT			
employer name		occupation		
address				
city		state	zip code	

Whom may we thank for referring you? _____

Have you ever seen a chiropractor before? Yes No **if Yes, who** _____

- I understand and agree to the following:
- 1) A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services.
 - 2) It is my responsibility to complete the clinic's forms accurately and to notify the doctor if any of my information has changed or requires updating.
 - 3) Original x-rays are the property of Delafield Chiropractic and may be checked out on a per need basis, but need to be returned to our clinic as soon as possible or within 60 days.

Patient or Guardian Signature Date

PATIENT CASE HISTORY

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PATIENT ID #

DATE

1	PATIENT INFORMATION
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last name	first name	m.i.
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2	HEALTH COMPLAINTS
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Are you here because you were injured <input type="radio"/> working <input type="radio"/> auto accident <input type="radio"/> home <input type="radio"/> other _____
To whom have you made a report of your injury? <input type="radio"/> employer <input type="radio"/> auto insurance <input type="radio"/> workers comp <input type="radio"/> other _____
If auto accident were you the <input type="radio"/> driver <input type="radio"/> passenger attorney name(if applicable)
What is your primary complaint?
How long have you been experiencing this primary complaint?
How does the primary complaint feel? <input type="radio"/> dull/achy <input type="radio"/> sharp <input type="radio"/> numb <input type="radio"/> tingling <input type="radio"/> burning <input type="radio"/> cold <input type="radio"/> throbbing <input type="radio"/> shooting <input type="radio"/> cramps <input type="radio"/> stiffness <input type="radio"/> swelling <input type="radio"/> other _____
How often do you experience the primary complaint? <input type="radio"/> constantly <input type="radio"/> daily <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly
If you have missed work because of your primary complaint, what was your last day of work?
What makes your symptoms better?
What do you believe is causing your primary complaint?
List other health complaints (2-5) on the following lines. 2 _____ 3 _____ 4 _____ 5 _____
Do you have any other condition other than what brings you here? <input type="radio"/> yes <input type="radio"/> no If YES, list it here: _____
What treatment have you already received for your condition? <input type="radio"/> medications <input type="radio"/> surgery <input type="radio"/> physical therapy <input type="radio"/> chiropractic services <input type="radio"/> none <input type="radio"/> other _____

PATIENT NAME	PATIENT ID #	DATE
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3 LIFESTYLES & HABITS

How many hours of television do you watch a day?	<input type="radio"/> <1	<input type="radio"/> 1-3	<input type="radio"/> 3-5	<input type="radio"/> >5		
Do you usually snack while watching television?	<input type="radio"/> yes	<input type="radio"/> no				
How many hours per day do you use a computer at work or home?	<input type="radio"/> <1	<input type="radio"/> 1-3	<input type="radio"/> 3-5	<input type="radio"/> >5		
How many hours per day do you ride in a car or other vehicle?	<input type="radio"/> <1	<input type="radio"/> 1-3	<input type="radio"/> 3-5	<input type="radio"/> >5		
How often do you exercise?	<input type="radio"/> daily	<input type="radio"/> 3x's/week	<input type="radio"/> 2x's/week	<input type="radio"/> 1x/week	<input type="radio"/> I don't exercise	
How long do your exercise work outs last?	<input type="radio"/> >1 hour	<input type="radio"/> 1 hour	<input type="radio"/> 30 minutes	<input type="radio"/> <30 minutes	<input type="radio"/> NA	
What are your exercise activities? (mark all that apply) <input type="radio"/> I don't exercise						
<input type="radio"/> walking	<input type="radio"/> swimming	<input type="radio"/> weight lifting				
<input type="radio"/> stretching/flexibility	<input type="radio"/> yoga/Pilates	<input type="radio"/> resistance bands				
<input type="radio"/> running/treadmill/rowing/climbing	<input type="radio"/> group exercise classes	<input type="radio"/> other _____				
How would you describe your work activity:	<input type="radio"/> sitting	<input type="radio"/> standing	<input type="radio"/> light labor	<input type="radio"/> heavy labor		
Do you take a multi-vitamin?	<input type="radio"/> yes	<input type="radio"/> no	If YES, what brand do you take?			
List any other nutritional supplements you are currently taking.						
<u>Supplement</u>	<u>reason</u>	<u>supplement</u>	<u>reason</u>	.		
<u>1</u>		<u>2.</u>		.		
<u>3</u>		<u>4</u>		.		
Have you ever used tobacco?	<input type="radio"/> never	<input type="radio"/> daily	<input type="radio"/> weekly	<input type="radio"/> monthly	<input type="radio"/> yearly	<input type="radio"/> quit
How many servings of alcohol do you drink each week?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> >5		
How many servings of coffee do you drink each day?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> >5		
How many servings of soda do you drink each day?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> >5		
How many servings of diet soda do you drink each day?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> >5		
How many servings of water do you drink each day?	<input type="radio"/> 0	<input type="radio"/> 1-2	<input type="radio"/> 3-5	<input type="radio"/> >5		

4 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	<input type="radio"/> yes <input type="radio"/> no	epilepsy	<input type="radio"/> yes <input type="radio"/> no	low back pain	<input type="radio"/> yes <input type="radio"/> no
polio	<input type="radio"/> yes <input type="radio"/> no	anemia	<input type="radio"/> yes <input type="radio"/> no	goiter	<input type="radio"/> yes <input type="radio"/> no
measles	<input type="radio"/> yes <input type="radio"/> no	rheumatic fever	<input type="radio"/> yes <input type="radio"/> no	appendicitis	<input type="radio"/> yes <input type="radio"/> no
heart disease	<input type="radio"/> yes <input type="radio"/> no	mental disorder	<input type="radio"/> yes <input type="radio"/> no	tuberculosis	<input type="radio"/> yes <input type="radio"/> no
arthritis	<input type="radio"/> yes <input type="radio"/> no	HIV positive	<input type="radio"/> yes <input type="radio"/> no	mumps	<input type="radio"/> yes <input type="radio"/> no
venereal infect	<input type="radio"/> yes <input type="radio"/> no	cancer	<input type="radio"/> yes <input type="radio"/> no	influenza	<input type="radio"/> yes <input type="radio"/> no
pleurisy	<input type="radio"/> yes <input type="radio"/> no	whiplash	<input type="radio"/> yes <input type="radio"/> no	diabetes	<input type="radio"/> yes <input type="radio"/> no
pneumonia	<input type="radio"/> yes <input type="radio"/> no	whooping cough	<input type="radio"/> yes <input type="radio"/> no	chicken pox	<input type="radio"/> yes <input type="radio"/> no

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5 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

Cancer	n p c	mother	n p c	father	n p c	brother	n p c	sister
diabetes	n p c	mother	n p c	father	n p c	brother	n p c	sister
heart problems	n p c	mother	n p c	father	n p c	brother	n p c	sister
kidney problems	n p c	mother	n p c	father	n p c	brother	n p c	sister

6 INJURIES

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		

List any **surgeries** that you experienced below. Begin with the most recent.

1.	2.
3.	4.

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		

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7 **HOSPITAL/MEDICINE**

Have you had breast implant surgery?	<input type="radio"/> yes	<input type="radio"/> no
Have you had knee or hip replacement surgery:	<input type="radio"/> yes	<input type="radio"/> no
Do you have a pacemaker?	<input type="radio"/> yes	<input type="radio"/> no
Do you have any other implantable medical devices in your body?	<input type="radio"/> yes	<input type="radio"/> no
Mark all of the following procedures as they pertain to you.		
vaccinations <input type="radio"/> yes <input type="radio"/> no	tubes in ears <input type="radio"/> yes <input type="radio"/> no	rectal surgery <input type="radio"/> yes <input type="radio"/> no
tonsillectomy <input type="radio"/> yes <input type="radio"/> no	appendectomy <input type="radio"/> yes <input type="radio"/> no	sinus surgery <input type="radio"/> yes <input type="radio"/> no
gall bladder removal <input type="radio"/> yes <input type="radio"/> no	female/male surgery <input type="radio"/> yes <input type="radio"/> no	hernia surgery <input type="radio"/> yes <input type="radio"/> no
back surgery <input type="radio"/> yes <input type="radio"/> no		thyroid surgery <input type="radio"/> yes <input type="radio"/> no
		stomach surgery <input type="radio"/> yes <input type="radio"/> no

List any prescription or over-the-counter medications you are currently taking.

Medication	Reason
1.	
2.	
3.	
4.	

Have you ever had a lapse of memory? yes no Were you ever knocked unconscious? yes no

List any broken bones or dislocations

Have you ever had a spinal tap or spinal injection? yes no

8 **PREGNANCY** **WOMEN ONLY**

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now. Are you pregnant? yes no On what date did your last period begin? _____

Mark the following situations as they pertain to you.

Tubal ligation <input type="radio"/> yes <input type="radio"/> no	complete or partial hysterectomy <input type="radio"/> yes <input type="radio"/> no	partner had a vasectomy <input type="radio"/> yes <input type="radio"/> no
less than 10 days since the start of my last period <input type="radio"/> yes <input type="radio"/> no	taking birth control pills <input type="radio"/> yes <input type="radio"/> no	

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9 **SYSTEM REVIEW**

Mark the following conditions that are **currently** a cause of significant concern for you.

GENERAL

loss of sleep	<input type="radio"/>	irregular sleep	<input type="radio"/>	excessive sleep	<input type="radio"/>	weight loss	<input type="radio"/>	weight gain	<input type="radio"/>
poor appetite	<input type="radio"/>	food cravings	<input type="radio"/>	poor digestion	<input type="radio"/>	headaches	<input type="radio"/>	fatigue	<input type="radio"/>
fever	<input type="radio"/>	chills	<input type="radio"/>	night sweats	<input type="radio"/>	dizziness	<input type="radio"/>	convulsions	<input type="radio"/>

MUSCLES, BONES, JOINTS

neck pain	<input type="radio"/>	back pain	<input type="radio"/>	joint pain	<input type="radio"/>	shoulder pain	<input type="radio"/>	elbow pain	<input type="radio"/>
hip pain	<input type="radio"/>	knee pain	<input type="radio"/>	ankle pain	<input type="radio"/>	foot pain	<input type="radio"/>	toe pain	<input type="radio"/>
hand pain	<input type="radio"/>	wrist pain	<input type="radio"/>	finger pain	<input type="radio"/>	muscle pain	<input type="radio"/>	muscle cramps	<input type="radio"/>
muscle weakness	<input type="radio"/>	joint swelling	<input type="radio"/>	spinal curvature	<input type="radio"/>	painful tailbone	<input type="radio"/>		

DIGESTION/ INTESTINES

heartburn	<input type="radio"/>	indigestion	<input type="radio"/>	belching	<input type="radio"/>	nausea	<input type="radio"/>	vomiting	<input type="radio"/>
vomiting blood	<input type="radio"/>	difficult to swallow	<input type="radio"/>	constipation	<input type="radio"/>	diarrhea	<input type="radio"/>	blood in stools	<input type="radio"/>
hemorrhoids	<input type="radio"/>	rectal bleeding	<input type="radio"/>	rectal pain/itch	<input type="radio"/>	abdominal pain	<input type="radio"/>	liver problems	<input type="radio"/>
cramping bowels	<input type="radio"/>	gassy gut	<input type="radio"/>	list any foods that bother you _____					

CARDIO-VASCULAR

poor circulation	<input type="radio"/>	cold hands/feet	<input type="radio"/>	chest pain	<input type="radio"/>	lightheadedness	<input type="radio"/>	palpitations	<input type="radio"/>
consistent fainting	<input type="radio"/>	swelling feet/ankle	<input type="radio"/>	blood clots	<input type="radio"/>	varicose veins	<input type="radio"/>	strokes	<input type="radio"/>
high blood pressure	<input type="radio"/>	low blood pressure	<input type="radio"/>	rapid heart	<input type="radio"/>	slow heart	<input type="radio"/>	heart trouble	<input type="radio"/>
bruise easy	<input type="radio"/>	anemia	<input type="radio"/>						

EAR/EYE/NOSE/THROAT

ringing ears	<input type="radio"/>	poor hearing	<input type="radio"/>	earache	<input type="radio"/>	ear discharge	<input type="radio"/>	ear noises	<input type="radio"/>
pain in eyes	<input type="radio"/>	blurred vision	<input type="radio"/>	wear corrective lens	<input type="radio"/>	crossed eyes	<input type="radio"/>	nasal obstruction	<input type="radio"/>
nose bleeds	<input type="radio"/>	postnasal drip	<input type="radio"/>	sinus problems	<input type="radio"/>	hay fever	<input type="radio"/>	trouble taste/smell	<input type="radio"/>
sore throat	<input type="radio"/>	tonsillitis	<input type="radio"/>	hoarseness	<input type="radio"/>	thyroid trouble	<input type="radio"/>	bad breath	<input type="radio"/>
facial pain	<input type="radio"/>	jaw clicks	<input type="radio"/>	teeth problems	<input type="radio"/>	grinding teeth	<input type="radio"/>	trouble chewing	<input type="radio"/>

RESPIRATORY

shortness of breath	<input type="radio"/>	wheezing	<input type="radio"/>	asthma	<input type="radio"/>	frequent colds/flu	<input type="radio"/>	chronic cough	<input type="radio"/>
spitting blood	<input type="radio"/>	spitting phlegm	<input type="radio"/>						

MOOD, THOUGHTS, EMOTIONS

depression	<input type="radio"/>	loneliness	<input type="radio"/>	panic or fear attacks	<input type="radio"/>	hopelessness	<input type="radio"/>	nervousness	<input type="radio"/>
anger problems	<input type="radio"/>	apathy	<input type="radio"/>	don't care anymore	<input type="radio"/>	anxiety	<input type="radio"/>	feel isolated	<input type="radio"/>

SKIN, HAIR, BREASTS

eczema	<input type="radio"/>	dryness	<input type="radio"/>	hives	<input type="radio"/>	itching	<input type="radio"/>	rashes	<input type="radio"/>
sensitive skin	<input type="radio"/>	hair loss	<input type="radio"/>	mole changes	<input type="radio"/>	breast lumps/pain	<input type="radio"/>	breasts leak fluid	<input type="radio"/>

URINE, KIDNEYS, BLADDER

decreased urine flow	<input type="radio"/>	blood/pus in urine	<input type="radio"/>	painful urination	<input type="radio"/>	kidney stones	<input type="radio"/>	wake to urinate	<input type="radio"/>
frequent urination	<input type="radio"/>	loss control of urine	<input type="radio"/>	sudden urges to pee	<input type="radio"/>				

NERVES, MOVEMENT, BRAIN

seizures	<input type="radio"/>	nerve pain	<input type="radio"/>	poor balance	<input type="radio"/>	poor coordination	<input type="radio"/>	tremor/shaking	<input type="radio"/>
numbness	<input type="radio"/>	poor memory	<input type="radio"/>	twitching	<input type="radio"/>				

WOMEN

cramps	<input type="radio"/>	excessive flow	<input type="radio"/>	hot flashes	<input type="radio"/>	irregular cycle	<input type="radio"/>	painful periods	<input type="radio"/>
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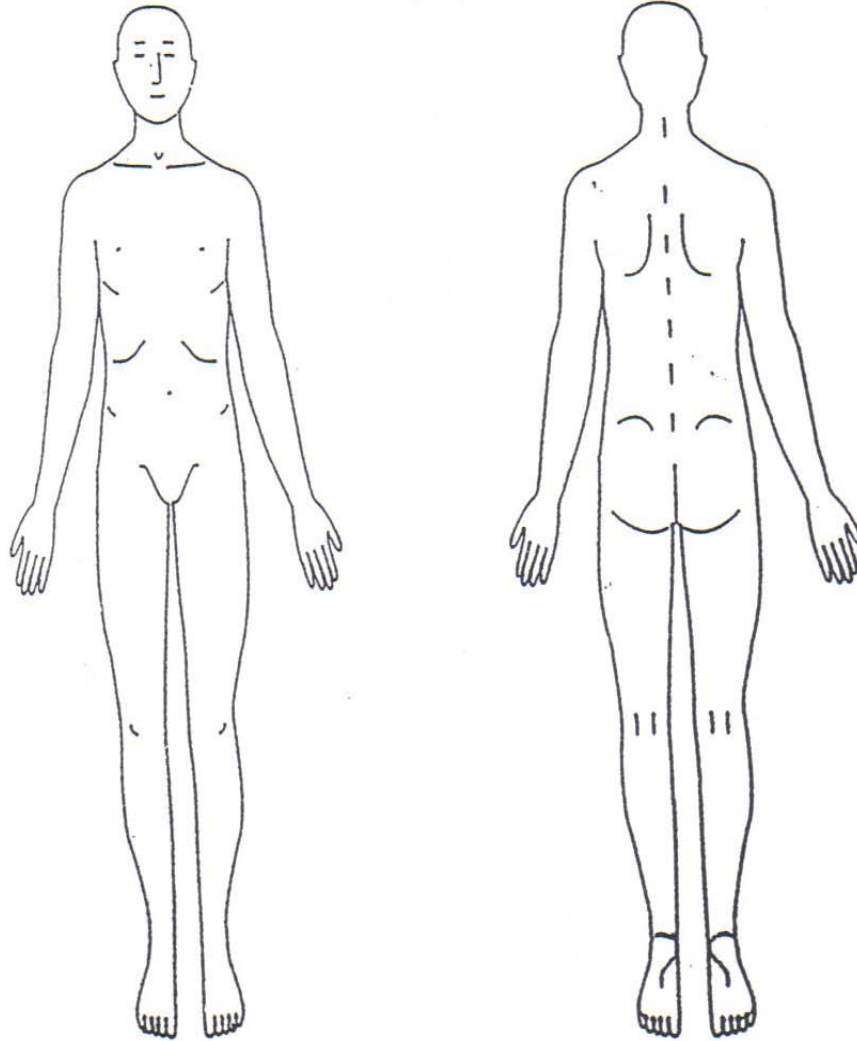
Pain Drawing

Please be sure to fill this out extremely accurately. On the diagram below mark the area on your body where you feel the described sensation(s). Use the appropriate abbreviation(s), mark areas of radiating pain, and include all affected areas.

Dull/Achy Pain = D
Sharp Pain = S

Numbness = N
Tingling = T

Stiffness = F
Throbbing = B



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain. If there is more than one area write the area (example: neck, mid-back, low back, etc.) beside your mark.

a.) Right Now: No Pain 0-----50-----100 Unbearable

b.) At Worse: No Pain 0-----50-----100 Unbearable

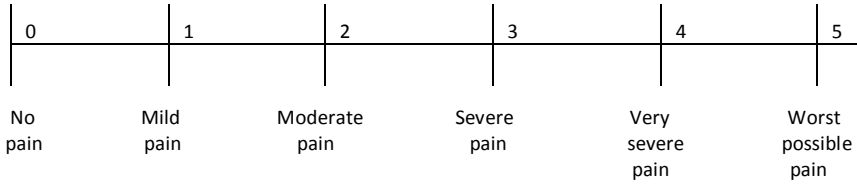
Visual Function Index

We must understand how much your pain has affected your ability to manage everyday activities. Please, circle one choice which most closely describes your problem right now.

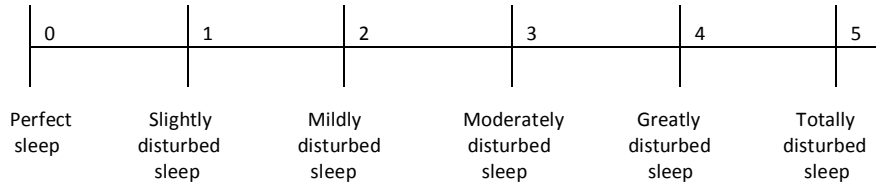
Name _____

Date _____

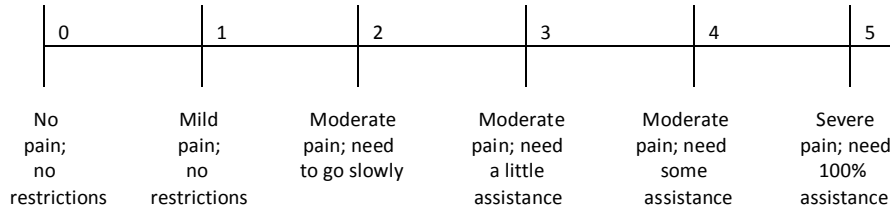
1. Pain Intensity



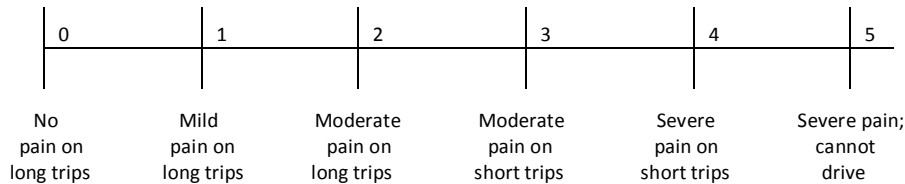
2. Sleeping



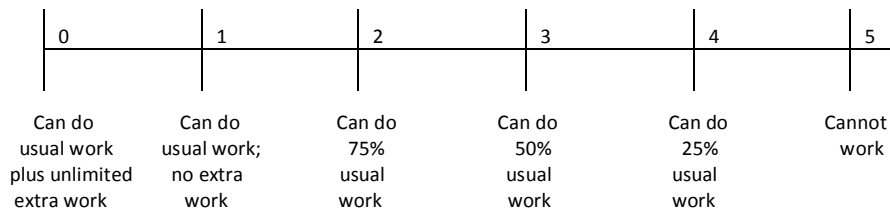
3. Personal Care (washing, dressing, etc.)



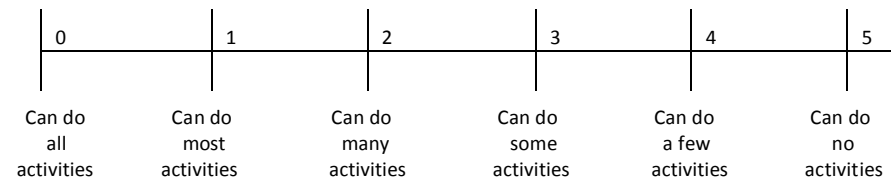
4. Driving



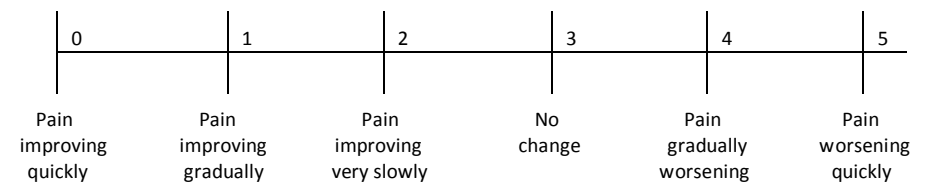
5. Work



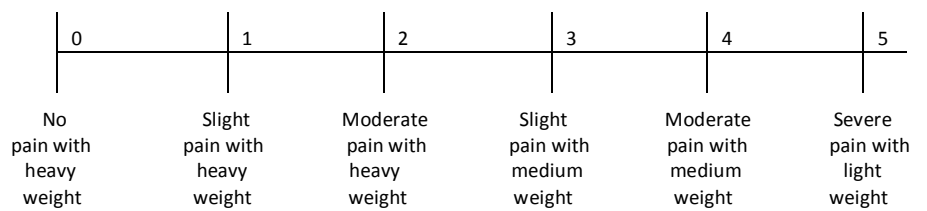
6. Recreation



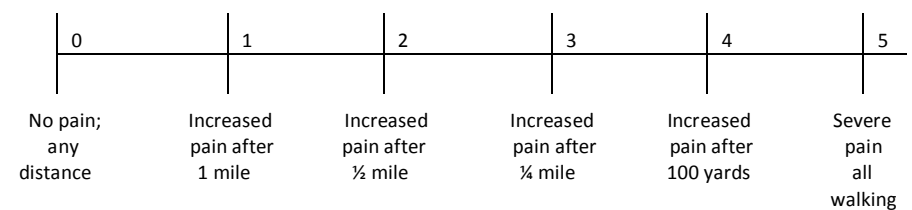
7. Change of pain



8. Lifting



9. Walking



10. Standing

