CHIROPRACTIC CARE CENTER ~ FRANKLIN

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

WORK RELATED / AUTO ACCIDENT PATIENT HEALTH HISTORY

Name _____ Today's Date _____

Address _____City/State_____ Zip _____

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

Email Address _____

May we contact you by phone call, text and/or email? Please circle: Yes / No

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: _____

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? _____

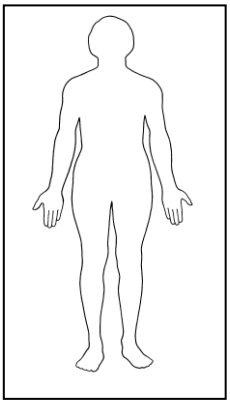
What other treatments have you tried? (Please circle): Massage Physical Therapy Chiropractic
Medicine (Rx/OTC) Cortisone Surgery Other (Explain) _____

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

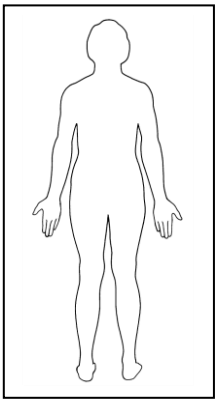
Use Codes:

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 and pain relievers.)

Name of Medication **Reason?** **Date started?** **Strength?** **Dosage?** **What 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 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)_____

WORK RELATED OR AUTO ACCIDENT INJURY QUESTIONAIRE

Date of Accident _____ Time of Accident _____ ☐AM ☐PM

City of Accident _____ County of Accident _____

WORK RELATED INJURY

Was your accident directly related to your work? Yes or No

Describe how your accident occurred: _____

Employer Name: _____

Employer Address: _____

Was anyone present at the time of your injury? ☐Yes ☐No

Did you report your accident to your employer? ☐Yes ☐No If yes, to whom? _____

Is your job physically stressful? ☐Yes ☐No Is your workplace noisy? ☐Yes ☐No

Is your job mentally stressful? ☐Yes ☐No Have you changed jobs in the last year? ☐Yes ☐No

Are you still employed by the above employer? ☐Yes ☐No

Has this type of accident happened to you before? ☐Yes ☐No

How many hours are in your normal work day? _____

Please indicate your regular daily job duties and any activities which you are occasionally asked to perform.

☐Standing	☐Driving	☐Operating equipment
☐Sitting	☐Twisting	☐Work with arms above head
☐Walking	☐Crawling	☐Computer (keyboard/mouse)
☐Lifting	☐Bending	☐Stooping
☐Other _____		

What positions can you work in with minimum physical effort and for how long? _____

Do you work with others who can help you with any heavy lifting? ☐Yes ☐No ☐N/A

While in recovery, is there any light duty work you could request? ☐Yes ☐No ☐N/A

AUTO ACCIDENT INJURY

Were you the: Driver Front Passenger Rear Passenger

If a traffic citation was issued, to whom was it issued? _____ Number of people in accident vehicle _____

Did the police come to the accident site? ☐Yes ☐No Was a police report filed? ☐Yes ☐No

Were there any witnesses? ☐Yes ☐No Were you wearing your seat belt? ☐Yes ☐No

Was this vehicle equipped with airbags? ☐Yes ☐No If yes, did it/they inflate? ☐Yes ☐No

In relation to the base of your skull, where was the headrest? ☐Above ☐Below ☐At base of skull

What did your vehicle impact? ☐Another vehicle ☐Other If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐Yes ☐No

If yes, please describe: _____

Make & model of the car you were occupying: _____

Name of the location/street on which you were traveling: _____

What was the approx. speed of your vehicle: _____

Did the impact to your vehicle come from the: ☐Front ☐Rear ☐Right Side ☐Left Side ☐Other

During impact, were you facing: ☐Right ☐Left ☐Forward

Were you ☐Aware or ☐Surprised by the impact?

If accident vehicle made impact with another vehicle:

Make and model of other vehicle _____ Speed of the other vehicle: _____

In your words, please describe the accident: _____

_____

_____

WORK RELATED OR AUTO ACCIDENT INJURY DETAILS

Did the accident render you unconscious? ☐Yes ☐No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a Hospital or seen any other Doctor? ☐Yes ☐No

When did you go? ☐Just after the accident ☐The next day ☐2 days plus

How did you get there? ☐Ambulance ☐Private transportation

Name of Hospital and/or Attending doctor: _____

Was she/he a: ☐D.C. ☐M.D. ☐D.O. ☐D.D.S. Describe any treatment you received: _____

Were X-rays taken? ☐Yes ☐No Was medication prescribed? ☐Yes ☐No

Have you been able to work since this injury? ☐Yes ☐No

Are your work activities restricted as a result of this injury? ☐Yes ☐No

Indicate the symptoms that are a result of this accident:

☐Dizziness	☐Difficulty sleeping	☐Jaw problems	☐Nausea
☐Memory loss	☐Irritability	☐Arms/Shoulder pain	☐Back pain
☐Headache(s)	☐Fatigue	☐Numb Hands/ Fingers	☐Low back pain
☐Blurred vision	☐Tension	☐Chest pain	☐Back stiffness
☐Buzzing in ear	☐Neck pain	☐Shortness of breath	☐Leg pain
☐Ears Ringing	☐Neck Stiff	☐Stomach Upset	☐Numb Feet/Toes

☐Other _____

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	☐ 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 _____