Patient Information

Date _____________ Last Name ____________________________ First Name ___________________ Middle Initial ______

Street Address ____ City ________________________ State _____ Zip _________

Home Phone __________________ Work/Day Phone _________________ Ext __________ Cell Phone _________________

Social Security # __________________________ Female Male Birthdate ___________________ Age _________

Marital Status: Married Single E-mail __________________________________ Occupation ___________________

Employer's Name & Address ____

How did you hear about us? ____

Emergency Contact Information

Last Name ______________________________________ First Name _________________________ Middle Initial _________

Relationship to you ______________________________ Phone _____________________________

Parent/Guardian Information (if applicable)

Parent/Guardian ____ Relationship to Patient __________________________

Full Address (if different from patient) ____

Phone Number ____________________ Birthdate _______________ Social Security Number __________________________

Has this person been a patient in one of our clinics? Yes No

Injury Information

Were you injured at work? (Are you filing a worker's compensation claim?) Yes No

Were you in an auto or other accident? (Are you filing a third-party accident claim?) Yes No

---

I request Stramara Chiropractic, S.C. to file to my insurance (if applicable); therefore, I hereby authorize release of any information necessary to process my claim. I understand that regardless of insurance, I am responsible for services/items not covered by insurance. I further authorize direct payment of my benefits to Stramara Chiropractic, S.C..

____ Patient or Parent Signature if Patient is a Minor

_____________________________ Relationship (if applicable)

___________ Date

Stramara Chiropractic, S.C. - Patient Symptom Record

501 Hall Street Watertown, WI 53094 (920) 261-5784 www.drstramara.com

Name ______________________________ Date ____________________

The following information is required by Federal Law for us to comply with Electronic Health Records requirements.

Preferred Language: English Other: ____________ **Race:** Caucasian Hispanic/Latino Other________________

Height: __________ **Weight:** ___________

1) Major complaint:	2) How long has it existed?

3) How did it occur?	4) Onset? Gradual Sudden	5) Frequency? (% of the day) Intermittent (0-25%) Occasional (26-50%) Frequent (51-75%) Constant (76-100%)

6) What makes the pain worse?	7) What relieves the pain?

8) Pain Level:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

9 & 10) **Please use the symbols on the left to mark the areas of your main complaint**

A = Ache B = Burning

D = Dull

H = Throbbing

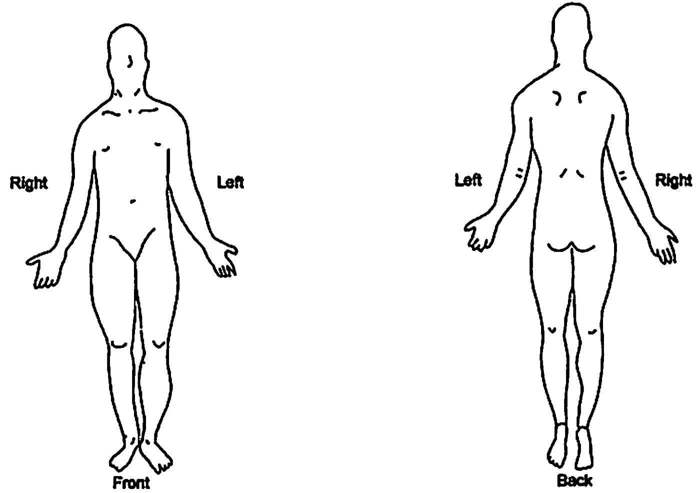
N = Numbness

P = Pressure

R = Radiating/Shooting

S = Sharp/Shooting/Stabbing

T = Tingling



Activities of Daily Living: Please indicate which activities you **currently have difficulty performing** as a result of your condition

☐ Lying on Back	☐ Cough/Sneeze	☐ Walking	☐ Standing	☐ Get in or out of car
☐ Lying on sides	☐ Bending	☐ Kneeling	☐ Getting dressed	☐ Sitting
☐ Lying on stomach	☐ Reaching	☐ Lifting	☐ Twist/Turn Right	☐ Using Computer
☐ Turning over in Bed	☐ Push/Pull	☐ Using Stairs	☐ Twist/Turn Left	☐ Transition from sitting

Other activity not listed above:

____

Name ______________________________________

For This Episode:
11) List prior treatments/Professional Care: ____

12) List any Medications taken:

FOR WOMEN ONLY Are you or do you think you may be pregnant? ___ No ___ Yes If YES, due date ____________

13) Family History (Please check all that apply)	Mother	Father	Siblings	Grandparents	Notes
Arthritis (including Rheumatoid)					
Scoliosis					
Multiple Sclerosis					
Diabetes					
Heart Disease & Stroke					
Cancer					
Other:					

14) **Past Medical History**

Name of Primary Care Physician/MD: ____

Have you had previous Chiropractic care?
☐ No ☐ Yes – Doctor/Clinic Name: ____

Describe any previous Hospitalizations, Infections, Traumas (accident/injury) or Surgeries:
____
____

ANY medications that you are presently taking (prescribed/non-prescribed): ______________________
____
____

Please list any allergies you have to Medicines/Food/Environment/Other:

15) **Social History**

Occupation: ____________________ Recreational activities/Hobbies/Sports: ____________________

Do you exercise? ☐ No ☐ Yes – How Often? ______________ What Type: ______________

Do you use a computer? ☐ No ☐ Yes – How many days per week? _____ How many hours per day (average)? _____

Please circle smoking status: Never Smoked Former Smoker Current/Daily Current/Occasional

Do you drink alcohol? ___ No ___Yes
Frequency ______________________

Do you consume caffeine? ___ No ___Yes
Frequency ______________________

16) Review of Systems

Constitutional	Cardiovascular	Neurological
☐ I deny any ☐ Unexplained weight loss/gain ☐ Fatigue/malaise/lethargy ☐ Fever ☐ Cancer ☐ Chills	☐ I deny any ☐ Chest Pain ☐ Heart attack ☐ Stroke ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Palpitations	☐ I deny any ☐ Tingling ☐ Numbness ☐ Limb weakness ☐ Speech problems ☐ Headaches ☐ Dizziness ☐ Seizures ☐ Stress ☐ Balance Problems
Ears, Nose and Throat	**Respiratory**	**Gastrointestinal**
☐ I deny any ☐ Sinus pain ☐ Nasal congestion ☐ Ear pain ☐ Ringing in ears (tinnitus) ☐ TMJ problems	☐ I deny any ☐ Shortness of breath ☐ Exercise intolerance ☐ Asthma ☐ Cough	☐ I deny any ☐ Bloating ☐ Nausea/vomiting ☐ Constipation/diarrhea ☐ Indigestion ☐ Heartburn/GERD
Genitourinary	**Endocrine**	**Eyes**
☐ I deny any ☐ Frequent urination ☐ Nocturia (night urination) ☐ Kidney stones ☐ Burning Urination ☐ Prostate problems ☐ Irregular menstruation	☐ I deny any ☐ Diabetes ☐ Hypothyroid (decreased function) ☐ Hyperthyroid (increased function)	☐ I deny any ☐ Double vision ☐ Blurred vision ☐ Scotomas (visual defect) ☐ Wear contacts/glasses ☐ Cataracts

List any additional not found above:

____

Patient Name (Print) ______________________________

Patient Signature ______________________________ **Date** ______________

Guardian or Spouse (authorizing care if applicable) **Name (Print)** ______________________ **Date** __________

Guardian or Spouse (authorizing care if applicable) **Name Signature** ______________________ **Date** __________

10/2017

For Clinic Use Only:

Notes: ____

____

____

____