CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your **drivers license** and **insurance** details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Elite Chiropractic
2808 Prairie Lakes Dr, #105
Sun Prairie, WI 53590
T: (608) 825-7071
E: info@elitechiropracticwi.com

Today's Date (MM/DD/WW)

Patient Number (OFFICE USE ONLY)

Have you consultued a chiropractor before?
○ No ○ Yes

Whom may we thank for referring you?

When?

If so, whom?

Age ○ Male ○ Female

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White
○ Decline to answer

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Social Security Number

Preferred Language

Martial Status
○ Single ○ Divorce ○ Widowed ○ Separated ○ Married

Your First Name

Middle Name (or Initial)

Address

Spouse's Name

City

State/Province

ZIP/Postal Code

Smoking Status (age 13 and over)
○ Light Smoker ○ Never a Smoker
○ Heavy Smoker ○ Vape
○ Former Smoker

Home Phone

Cell Phone

Email Address

Emergency Contact

Emergency Contact Number

Number of Children

Your Ocupation

Work Number

Your Employer

May we contact you at work?
○ Yes ○ No

Address

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

City

State/Province

ZIP/Postal Code

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Middle Name (or Initial)

Insured's Birth Date (MM/DD/YYYY)

Insured's First Name

Who carries this policy?
○ Self ○ Spouse ○ Parent

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

_____

_____

And are the result of:
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior Interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical Therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

Secondary Complaint
The primary symptom that prompted me to seek care today is: _____

_____

_____

And are the result of:
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior Interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical Therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

Alternative Complaint
The primary symptom that prompted me to seek care today is: _____

_____

_____

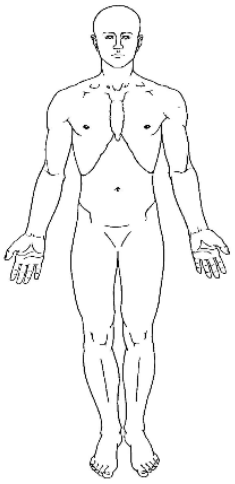
And are the result of:
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

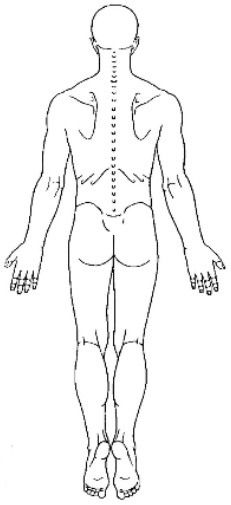
Onset (When did you first notice your current symptoms?) _____

Prior Interventions (What have you done to relieve the symptoms?)
- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical Therapy ○ Ice
- ○ Surgery ○ Heat
- ○ Other _____

Patient Number
(Office use only)

Location
(Where does it hurt?)
Mark current issues with an **O**
Mark past issues with an **X**





1. What else should Elite Chiropractic know about your current condition(s)? _____

_____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please mark the circle beside any condition that you've Had or Have and initial to the right.

1. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problem	○	○	Hip disorders	○ None Initials _____
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	

1. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness/Vertigo	○	○	Pin and needles	○	○	Numbness	○ None Initials _____

a. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor	○	○	Angina	○	○	Excessive bruising	○ None Initials _____

b. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	○ None Initials _____

c. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	○ None Initials _____

c. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Blurred	○	○	Ringing in ear	○	○	Hearing loss	○	○	Chronic ear infections	○	○	Loss of smell	○	○	Loss of taste	○ None Initials _____

d. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Skin	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	○ None Initials _____

e. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent urination	○	○	Swollen glands	○	○	Low energy	○ None Initials _____

f. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Kidney Stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile disfunction	○	○	PMS	○ None Initials _____

g. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have			
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (Circle one)	○	○	Weakness	○ None Initials _____

Primary Complaint

Intensity (How extreme are your current symptoms?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent — Uncomfortable — Agonizing

Quality of symptoms (What does it feel like?)

○ Numbness	○ Aching	○ Burning
○ Tingling	○ Cramps	○ Shooting
○ Stiffness	○ Nagging	○ Throbbing
○ Dull	○ Sharp	○ Stabbing

○ Other _____

_____

Secondary Complaint

Intensity (How extreme are your current symptoms?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent — Uncomfortable — Agonizing

Quality of symptoms (What does it feel like?)

○ Numbness	○ Aching	○ Burning
○ Tingling	○ Cramps	○ Shooting
○ Stiffness	○ Nagging	○ Throbbing
○ Dull	○ Sharp	○ Stabbing

○ Other _____

_____

Alternative Complaint

Intensity (How extreme are your current symptoms?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent — Uncomfortable — Agonizing

Quality of symptoms (What does it feel like?)

○ Numbness	○ Aching	○ Burning
○ Tingling	○ Cramps	○ Shooting
○ Stiffness	○ Nagging	○ Throbbing
○ Dull	○ Sharp	○ Stabbing

○ Other _____

_____

Patient Initials

Patient Number
(Office use only)

Past Personal, Family and Social History

Please identify your past history, including accidents, injuries, illness, and treatments. Please complete each section fully.

Personal

4. Illness

Check the illness you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Stroke
○	○	Alcoholism	○	○	Tuberculosis
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Covid-19			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Lymes			
○	○	Polio			
○	○	Rheumatic fever			
○	○	RSV			
○	○	STD			

5. Operations

Surgical interventions, which may or may not have included hospitalization.

○ Appendix removal
○ Bypass surgery
○ Cancer
○ Cosmetic surgery
○ Elective surgery: _____
_____
○ Eye surgery
○ Hysterectomy
○ Pacemaker
○ Spine: _____
_____
○ Tonsillectomy
○ Vasectomy
○ Other: _____
_____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

○ Acupuncture
○ Antibiotics
○ Birth control
○ Blood Transfusions
○ Chemotherapy
○ Chiropractic care
○ Dialysis
○ Herbs
○ Homeopathy
○ Hormone replacement
○ Inhaler
○ Massage therapy
○ Physical therapy
○ Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins, and minerals you take)

_____
_____
_____
_____
_____

7. Allergies

Are you allergic to any medications?

_____
_____
_____
_____
_____

8. Injuries

Have you ever… Please specify

○ Been injured in an accident
○ Been knocked unconscious
○ Had a fractured or broken bone
_____
○ Had a spine or nerve disorder
_____
○ Used a crutch, cane or other support
_____
○ Used neck or back bracing
_____
○ Received a tattoo
_____
○ Had or have a body piercing
_____

Family

9. Family History

Some health issues are hereditary. Tell Elite Chiropractic about the health of your immediate family.

Relative	Age (if living)	State of Health Good	State of Health Poor	Illness	Age at death	Cause of death Natural	Cause of death Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○
_____	_____	○	○	_____	_____	○	○

10. Are there any other hereditary health issues that you know about? _____

_____

Social

11. Social History

Tell Elite Chiropractic about your health and stress levels.

Alcohol use	○ Daily	○ Weekly	How Much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How Much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How Much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How Much? _____	Vaccinated?	○ Yes	○ No
Pain relivers	○ Daily	○ Weekly	How Much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How Much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How Much? _____			

Hobbies: _____

_____

12. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying Down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of a car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household Chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

Patient Initials

Patient Number
(Office use only)

13. What is the major stressor in your life? _____ **14. How much sleep do you average per night** ___ **Hours**

15. What is the type and approximate age of your mattress and pillow?_____ **16. What is your prefered sleeping position?**_____

17. Describe you typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

_____

19. In addition to the main reason for your visit today, what addition health goals do you have?_____

_____

Consultation Notes

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ Initials — **I instruct the chiropractor to deliver care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____ Initials — **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

_____ Initials — **I realized that an X-ray examination mat be hazardous to an unborn child and certify that to the best of my knowledge I am NOT pregnant.**

_____ Initials — **I grant permission to be called to confirm or reschedule an appoint and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

_____ Initials — **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

_____ Initials — **I acknowledge that No-Show, No-Call appointments will incur a fee of $25 ($50 For a family visit) that will be charged to your payment method on file. (There is no penalty for your FIRST No-Show, No-Call appointment.)**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____
Patient's (or Guardian's) signature

_____
Date (MM/DD/YYYY)

_____
Doctor's Initials