Lake Wissota
Family Chiropractic
"Care for the whole family!"

New Patient Application

Name: _____ Middle Initial ___ Age: _____ Today's Date: ____/____/ ____

Address: _____
Residence and mailing City State Zip Code

Home Telephone ( ) _____ Work ( ) _____ Cell ( ) _____

Email address for our newsletter and updates _____
Sex at Birth: Male [ ] Female [ ] Gender Identity: Male [ ] Female [ ] Nonbinary [ ] Other[ ]
Social Security #_____ Birthday _____

Occupation/Employer_____

Single [ ] Married [ ] Divorced [ ] Widowed [ ] Number of children_____

Name of Insured_____ Insured DOB_____

Appointment reason(s):
_____

Emergency Contact: name_____ Relation_____
Home Telephone ( ) _____ Work ( ) _____ Cell ( ) _____

Who may we thank for referring you to our office?
_____

Chiropractic care

The basis behind chiropractic care is that "subluxation" (misalignment) can be caused by physical, emotional, or chemical stress to the body. This causes irritation or interference to the nervous system. Many times pain is the last symptom to appear, so many problems are not recognized until they become more severe. The first subluxation can occur as early on as during the birthing process.

Childhood History-Birth to age 17

Yes No Unsure Explain

Did you have and childhood illnesses? (chicken pox, mumps etc.) [ ] [ ] [ ] _____

	Yes	No	Unsure	Explain
Did you have any serious falls or injuries as a child?	[ ]	[ ]	[ ]	_____
Did you play youth sports?	[ ]	[ ]	[ ]	_____
Did you take/use and drugs?	[ ]	[ ]	[ ]	_____
Did you have any surgery?	[ ]	[ ]	[ ]	_____
Have you fallen/jumped from a height over three feet?	[ ]	[ ]	[ ]	_____
Were you involved in any motor vehicle accidents?	[ ]	[ ]	[ ]	_____
Was there any prolonged use of medicine (antibiotics, inhaler)	[ ]	[ ]	[ ]	_____
Did you suffer any other physical or emotional traumas	[ ]	[ ]	[ ]	_____
Were you vaccinated?	[ ]	[ ]	[ ]	_____
As a child were you under regular chiropractic care?	[ ]	[ ]	[ ]	_____

Adult Health History-18 to present

	Yes	No	Unsure	Explain (how much?)
Do/did you drink caffeine?	[ ]	[ ]	[ ]	_____
Do/did you use tobacco?	[ ]	[ ]	[ ]	_____
Do/did you drink alcohol?	[ ]	[ ]	[ ]	_____
Do/did Recreational drugs	[ ]	[ ]	[ ]	_____
Have you been in any accidents?	[ ]	[ ]	[ ]	_____
Have you had any surgery?	[ ]	[ ]	[ ]	_____
Do/did you play any adult sports?	[ ]	[ ]	[ ]	_____

On a scale of 1-10 describe your stress level (0=none/10=extreme)
Occupational_____ Personal_____

Current Condition

Briefly describe your current symptoms/condition _____
_____

Was injury or pain due to Home [ ], Work [ ], or Auto Accident [ ]?

The pain you are experiencing is [ ] Sharp [ ] Dull [ ] Comes and goes [ ] Constant [ ] Travels
What makes symptoms worse _____
What makes them better _____

It interferes with [ ] Work [ ] Sleep [ ] Walking [ ] Sitting [ ] Standing [ ] Hobbies [ ] Leisure

On a scale of 1(minimal)-10(worst possible pain), my pain is_____/10
Other doctors seen for this condition:
Chiropractor_____ Did it help? _____
Medical doctor_____ Did it help? _____
Other_____ Did it help?_____
Did they do any imaging (x-ray, CT, MRI) or lab work? _____

List any medication including birth control medication or natural supplements or vitamins you are taking and why:

_____

_____

_____

Review of Systems

Have you had any *past* or *present* health concerns with the following? If yes, please list dates and explain.

	Yes	No	Unsure	Explain
1. Headache	[ ]	[ ]	[ ]	_____
2. Eyes	[ ]	[ ]	[ ]	_____
3. Ears	[ ]	[ ]	[ ]	_____
4. Nose/Sinus	[ ]	[ ]	[ ]	_____
5. Throat	[ ]	[ ]	[ ]	_____
6. Heart/Circulation	[ ]	[ ]	[ ]	_____
7. Lungs	[ ]	[ ]	[ ]	_____
8. Thyroid	[ ]	[ ]	[ ]	_____
9. Digestion/Stomach or bowels	[ ]	[ ]	[ ]	_____
10. Diabetes	[ ]	[ ]	[ ]	_____
11. Urination/bladder	[ ]	[ ]	[ ]	_____
12. Reproduction/Sexual Function	[ ]	[ ]	[ ]	_____
13. Mental health	[ ]	[ ]	[ ]	_____
14. Skin	[ ]	[ ]	[ ]	_____
15. Numbness/Tingling	[ ]	[ ]	[ ]	_____
16. Neuromusculoskeletal	[ ]	[ ]	[ ]	_____
17. Back/Neck/Arthritis	[ ]	[ ]	[ ]	_____

Family History (parents, siblings, grandparents)

1. Heart, BP, Cholesterol problems_____
2. Diabetes_____
3. Cancer_____
4. Neurologic_____
5. Thyroid_____
6. Back/Neck/Arthritis_____

These statements are accurate to the best of my knowledge.

_____ _____

Signed date