Rising Health Chiropractic Wellness

617 Ryan St. Suite 240, Pewaukee, WI 53072 • Phone 262-695-9698 • www.rhchirowellness.com

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. Thank you.

Name ____ Social Security Number_________-_____-_________

Address____ City______________________ State____ Zip___________

Home __________________________ Work___________________________ Cell _______________________________

Date of Birth________________________ Female ____ Male ____ Marital Status: M S W D #Children _______

Occupation___________________________ Employer ______________________ Referred ________________________

Spouse's Name____ Cell Phone_______________________________

Ethnicity: Caucasian Black Hispanic Asian Other ______________________

Preferred Language __________________________________

PRESENT COMPLAINT

Current health complaint for consulting our office: ____

What do you think caused this condition? ____

How long have you had this condition(s)? _______________ Have you had this or similar conditions in the past?_________

What positions/activities make your symptoms worse?____

What positions/activities make your symptoms better?____

Is this condition: ____ Improving ____ Unchanged ____ Getting Worse

Is this condition interfering with your _____Work _____ Sleep _____ Daily Routine

Please describe ____

Have you tried home therapy such as ice, heat or over the counter medications for this condition? (what, how long, did it work, results)

____

Have you been seen by any another health care provider(s) for this condition? Yes _____ No _____

Name/dates ____

For this condition were there any x-rays, MRI or CT scans taken? Yes ______ No ______ Date ___________________

Do you have any other complaints not covered in primary complaint? Yes ______ No ______

If yes, explain ____

What describes the nature of your symptoms? (***circle*** *all that apply*)

a. Sharp	c. Numb	e. Burning
b. Dull ache	d. Shooting	f. Tingling

How often do you experience your symptoms?

______ Constantly (76-100% of the time) ______ Frequently (51-75% of the time)

______ Occasionally (26-50% of the time) ______ Intermittently (0-25% of the time)

MARK (X) THE AREAS OF YOUR SYMPTOMS ON THE FIGURE(S) BELOW.

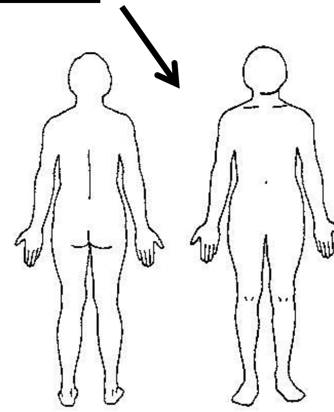
CIRCLE A NUMBER THAT CORRESPONDS TO YOUR SYMPTOMS.

How intense are your symptoms **now**?

None 0 1 2 3 4 5 6 7 8 9 10 Most Severe

How intense have they been in the **past week**?

None 0 1 2 3 4 5 6 7 8 9 10 Most Severe



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CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? ____ Yes _____ No Name ____

Date of last chiropractic visit. ______________ Reason for care/duration of care ____________________________________

Are there other family members under chiropractic care? ____ Yes____ No Whom? ________________________________

Are you wearing: ____Heel lifts ____Sole lifts ____ Inner soles ____ Arch supports

HEALTH HISTORY

Current Weight _________________ Height ________________________ Blood Pressure (if known) ______________

List surgical operations and year performed: ____

____

____

Have you been in an auto accident? ____ Past five years ____ Over five years ____ Never

Have you ever had any other personal injury or accident: ____ Past year ____Past five years ____ Over five years ago

Describe ____

Primary Care Physician ______________________________________ Date of last physical examination_________________

In what position do you sleep? __ Side __ Back __ Stomach How many hours do you sleep? ___________________

FEMALES: Please check one
Is there a possibility of you being pregnant? ____Yes ____ No

Smoking History: (circle one)

A. I have **never** smoked or chewed tobacco.

B. I **use to** smoke or chew tobacco. Began (year)__________ Quit(year)__________

C. I **currently** smoke or chew tobacco. _____< 10 cigarettes/day _____ 10-20/day _____ > 20/day

Patient: ____

Consumption of Alcohol and/or Caffeine:

Beer/Week ______________ Liquor/Week ______________ Wine/Week ______________ No. of Years ________________

Coffee/Week ____________ Tea/Week _____________ Cola/Week ____________ Energy Drinks/Week ________________

Medications &

dosage:____

____

____

____

____

Allergies:____

____

Daily Activity:

Mental Work: Heavy Moderate Light hours per day _______

Physical: Heavy Moderate Light hours per day_______

Exercise : Cardio hours per week_______ Weights hours per week_______

Family Health History (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.) examples: cancer, heart disease, diabetes, high blood pressure

Name	Relation	Past and Present Health Problems

Email Address:____

Rising Health Chiropractic uses email to correspond with patients for health updates, appointment reminders and paperless billing statements. If you wish to **NOT** have your email used for one or more of these please list which one(s) below.

____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his staff responsible for any errors that I may have made in the completion of this form.

Signature ____ Date ___________________________

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________
and assign to Rising Health Chiropractic Wellness all insurance benefits, if any otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company.
I hereby authorize the clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature ____ Date _________________________

Parent/Guardian ____ Date __________________________