Wisconsin
Family & Sports
Chiropractic

Patient Information

Date ___/___/___

Patient Name (last, first) ____ Sex: Male / Female

Home Phone # (______)____________________ Cell Phone # (______)________________

E-Mail Address _______________________________________ Insurance: ____________________

Address ___________________________ City _________________ State ______ Zip Code _______

Date of Birth ____/____/____ Age _______ Occupation ______________________________________

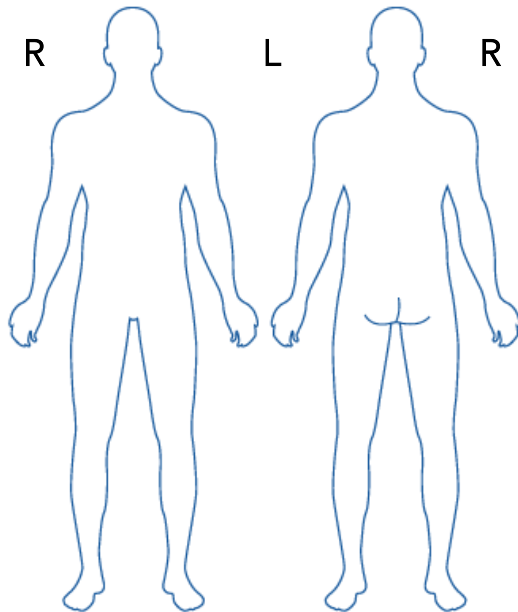
How Did You Hear About Us? ____

Would you like appointment reminders? (select one) EMAIL reminders | TEXT reminders

If you would like TEXT reminders, what is your cell phone provider? AT&T Verizon Other:__________

Using the symbols below, mark on the body the areas where you feel that particular sensation.

Numbness	Pins & Needles	Burning	Aching	Sharp/Stabbing
+++++	00000	XXXXX	*******	//////



PLEASE CIRCLE YOUR LEVEL OF DISCOMFORT: (1 = Minimal Pain; 10= Worst Pain Imaginable)
PAIN CURRENTLY 1 2 3 4 5 6 7 8 9 10
PAIN AT ITS WORST 1 2 3 4 5 6 7 8 9 10
PAIN TYPICALLY 1 2 3 4 5 6 7 8 9 10

Reason for Appointment:____

____

When did this begin?______________________ Has it happened before? When? _______________

How did this occur?____

Since it began, has it: Improved Worsened Unchanged

What have you done for this condition? ____

Wisconsin Family & Sports Chiropractic

Who have you seen for this condition? ____

Can you perform your daily activities?	All activities	Only some	Not at all
Do you exercise?	Daily	Occasionally	Not at all

Please list any previous surgeries, hospitalizations, injuries (motor vehicle accidents):______________________

____

Have you had any fractures or dislocations? ____

Have you had previous chiropractic care? Yes No Doctor:_________________ Date:_________

Review of Systems: Please check off all symptoms you are currently experiencing

General
___Allergy
___Chills
___Convulsions/tremors
___Dizziness/fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss/gain
___Nervousness/anxiety
___Neuralgia (nerve pain)
___Sweats
___Psoriasis/eczema
___Depression

Eyes, Ears, Nose, Throat
___Asthma
___Deafness
___Dental decay
___Earache/ringing
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Gum trouble
___Hoarseness
___Nasal obstruction

Musculoskeletal
___Arthritis
___Bursitis
___Hernia
___Low back pain
___Mid back pain
___Neck pain/stiffness
___Numbness/tingling
___Muscle weakness
___Muscle twitching
___Sciatica
___Spinal curvature
___Fractures

Genito-urinary
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection/stones
___Painful urination
___Prostate issues
___Pus in urine

Women Only
___Painful menstruation
___Irregular cycle
___Birth control pills
___Pregnancy complications

Cardiovascular
___High blood pressure
___Low blood pressure
___Heart disease
___Pain over heart
___Poor circulation
___Swelling of ankles

Respiratory
___Chest pain
___Chronic cough
___Difficulty breathing
___Spitting up blood
___Wheezing

Gastrointestinal
___Belching or gas
___Abdominal pain
___Constipation
___Diarrhea
___Difficult digestion
___Poor appetite
___Ulcers
___Vomiting
___Abdominal bloating
___Heartburn/reflux
___Hemorrhoids
___Gallbladder issues
___Colitis
___Irritable bowel syndrome

Current **Non-Prescription** Medications:

___Tylenol ___Asprin
___Ibuprofen ___None
___Other:______________________________

How often?
___Daily ___Weekly ___Other

Current **Prescription** Medications:

___Anti-inflammatory ___Birth Control Pill ___Nerve Pills
___Pain Relievers ___Cholesterol ___Hormone Replace
___Muscle Relaxers ___Insulin ___Sleeping Pills
___Blood Pressure ___Thyroid Meds ___Recent Antibiotics
___ADHD ___None
___Other:____

Wisconsin
Family & Sports
Chiropractic

Have you ever experienced the following conditions?			
Whiplash injury (cervical sprain)	Yes	No	Date__________
Were you ever a smoker?	Yes	No	From________To_________
Visual disturbances? (blur, loss, double)	Yes	No	Packs/Day _______
Hearing disturbances? (loss, ringing)	Yes	No	
Slurred speech or other speech problems	Yes	No	
Difficulty swallowing	Yes	No	
Dizziness	Yes	No	
Loss of consciousness/blackouts	Yes	No	
Numbness, loss of sensation, strength/weakness	Yes	No	
Sudden collapse without loss of consciousness	Yes	No	

LEGAL INFORMATION: By signing below, I agree that I have read and understand all of the information held within the following forms (listed below as 1-4) that have been provided to me. I also agree that any and all questions I may have had were completely answered prior to signing this.

1. **Informed Consent for Care**
   a. Pages 5-6
   b. I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction Prior To My Signing This Consent Form. I have made my decision voluntarily and freely.
2. **Notice of Privacy Practices**
   a. Pages 7-10
3. **Financial Policy**
   a. Page 11
   b. I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously. I understand that there is a $25.00 cancelation fee for missed appointments and appointments that are not canceled within 24 hours of the scheduled time.
4. **Assignment of Benefits**
   a. Page 12

WISCONSIN FAMILY & SPORTS CHIROPRACTIC HIPPA POLICY: I also certify that I have been given the opportunity to read Wisconsin Family & Sports Chiropractic's HIPPA policy. I realize that at any time I can request a copy of the HIPPA policy and may ask for clarification. At this time I feel I have a full understanding of the policy. By signing this form, it acknowledges that I have read all the information on this sheet.

Patient Name: ____ Todays Date: ________________________

Patient Signature: _____________________________________