Breitbach Chiropractic
167 N. Main St.
Oregon, WI 53575
608-835-5353

PATIENT CONFIDENTIAL CASE HISTORY

CONTACT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address (For our office use only): _____

Preferred Method of Communication: _____Home Phone _____Cell Phone _____Work Phone _____ Email

Age: _____ Date of Birth: _____ Gender: _____

Employer: _____ Occupation: _____

Please check the appropriate box: □ Single □ Divorced □ Married □ Widowed □ Separated

Spouse's Name: _____ Phone: _____

Number of Children and Ages: _____

Emergency Contact Person: _____ Phone: _____

Whom may we thank for referring you? _____

Please discuss and/or release my medical information with: _____

INSURANCE INFORMATION

Please check one:

□ Insurance: If you wish to have your services billed to your Insurance Company please present your insurance card to a staff member.

- Insurance Carrier: _____

□ Non-Insurance: I agree to pay in full at the time of service.

*Please inform us if your current health condition is due to: □ Auto Accident □ Workers Compensation *Additional Form Required

HEALTH QUESTIONNAIRE

Reason(s) for visit: _____

Is this condition due to an accident? □ Yes □ No □ Auto □ Work □ Home □Other

Date of Accident: _____ Cause of Injury: _____

When did your symptoms appear? _____ Is this condition getting worse? □ Yes □ No

How often do you have this problem? _____ Is it **constant** or does it **come and go** ?

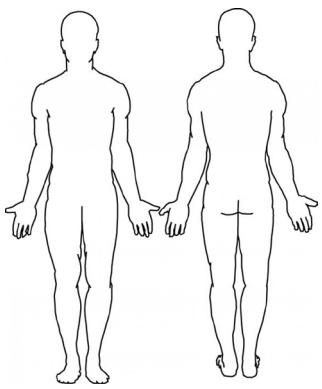
Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

Mark your pain on the scale of 1 to 10: At Rest: No Pain ☺ 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

With Activity: No Pain ☺ 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

Mark an "X" on the picture below where you continue to have pain, numbness, or tingling.



Indicate your ability to perform the following daily living activities.

Please use the following codes:
U – Unable L – Limited P – Painful D – Difficult N – Normal

___Lying on Back	___Lying on Sides	___Lying on Stomach
___Bending	___Bending Forward	___Kneeling
___Stooping	___Standing	___Sitting/Driving/Riding
___Dressing Self	___Twist/Turn – Lt / Rt	___Get In/Out of Car
___Lifting	___Pushing/Pulling	___Turning Over in Bed
___Gripping	___Reaching	___Cough/Sneeze/Grunt
___Walking	___Using Stairs	___Using Computer
___Sleeping	___Sexual Activity	Other:_____

MEDICATIONS

□ Blood Pressure □ Diabetic Meds □ Birth Control □ Steroids
□ Muscle Relaxant □ Antibiotics □ Antidepressant □ Antianxiety
□ Pain Medication □ Heart Meds □ Cholesterol Meds □ Thyroid Meds
Other:_____

(If you have a list of your medications, please present it to staff upon completion of the form.)

Vitamin/Herbs/Minerals/Supplements: _____

ALLERGIES

□ Pollen □ Dust □ Ragweed □ Latex □ Animals
Other:_____

PERSONAL HISTORY

Have you received chiropractic care in the past? □ Yes □ No
If yes, please give the date and the name of the chiropractor, as well as the reason for the previous care: _____
_____
Name of your Primary Medical Doctor:_____
Name of the Clinic/Hospital you attend: _____
Are you currently under the care of a healthcare provider? □ Yes □ No
If yes, for what condition(s): _____
Date of Last: Physical Exam _____ Spinal X-ray_____ Cholesterol_____ PSA_____
Mammogram _____ Pap Smear _____ Colon_____ MRI _____ CT_____

SYSTEM REVIEW QUESTIONS

Have you had any problems with the following areas Now or in the Past? (Y = Yes and N = No)

____Eyes (Glasses, Contacts, Cataracts, Glaucoma, Etc.)
____Respiratory (Lungs, Breathing, Asthma, COPD, Etc.)
____Gastro-Intestinal (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc.)
____Skin (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc.)
____Ears, Mouth, Nose, Throat (Hearing Loss, Sinus, Etc.)
____Neurological (Nerve Issues, Weakness, Numbness, Etc.)
____Genitourinary (Male/Female Reproductive, Kidney, Bladder, Etc.)
____Psychiatric (Anxiety, Depression, Bipolar, ADD/ADHD, Etc.)
____Cardiovascular (Heart, High BP, High Cholesterol, Etc.)
____Endocrine (Thyroid, Hormonal, Imbalances, Liver, Etc.)
____Musculoskeletal (Breaks, Arthritis, Osteoporosis, Discs, Etc.)
____Others:_____

Are you pregnant? □ Yes □ No Due Date: _____
How many? Pregnancies: _____ Live Births:_____ Miscarriages: _____
Describe any major Illnesses, Injuries, Falls, Hospitalizations, Accidents, or Surgeries:

Date	Doctor	Condition(s)	Results
			□ Full Recovery □ Complications
			□ Full Recovery □ Complications
			□ Full Recovery □ Complications

Have you ever:	Description	Date
Lost Consciousness		
Used a Cane/Crutch		
Had Mental/Emotional Disorders		
Been Treated for Spine/Nerve Disorder		

Do you have any other Health Conditions? (Check all that apply):

□ Alcoholism
□ Arthritis
□ Asthma
□ Cancer
□ Diabetes
□ Fractures
□ Gout
□ Heart Disease
□ Herniated Disk
□ High Blood Pressure
□ High Cholesterol
□ Mental Illness/Depression
□ Migraine Headaches
□ Multiple Sclerosis
□ Osteoporosis
□ Rheumatoid Arthritis
□ Stroke
□ Thyroid Problems
□ Other_____

SOCIAL HISTORY

Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Diet/Nutrition:

Are you on any special diet? □ Yes □ No If yes, for what reason? _____

Is your weight a concern for you emotionally or physically? □ Yes □ No

Have you gained or lost over 10 pounds in the past six months without wanting to? □ Yes □ No

My Diet is **High** In:
□ Fruits
□ Vegetables
□ Whole Grains
□ Lean Meats or Other Protein Sources
□ Saturated Fats
□ Sugars
□ Salt

My Diet is **Low** In:
□ Fruits
□ Vegetables
□ Whole Grains
□ Lean Meats or Other Protein Sources
□ Saturated Fats
□ Sugars
□ Salt

How many eight ounce glasses of water do you drink a day? _____

How many caffeine drinks do you drink a day? (Soda, Coffee, etc.) _____

Habits:

□ Smoking Packs/Day: _____

□ Alcohol Drinks/Week: _____

□ High Stress Level Reason: _____

□ Exercise □ None □ 1-3 times/week □ 4 or more times/week □ Moderate □ Heavy

We will work closely with you to resolve your chief complaint. As health professionals we are also concerned about your overall wellness. On future visits we will discuss other issues with you that may impact your overall health.

All of the answers I have given are correct to the best of my knowledge.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Legal Guardian Date