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: _____

Phone Number:_____Cell Number:_____ Work Number: _____

Email Address (For our office use only):_____

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:_____

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 at this time.

- Are you a Medicare patient? ☐ Yes ☐ No

  Do you have a secondary insurance carrier? ☐ Yes ☐ No

- Are you a Medicaid/Badger Care patient? ☐ Yes ☐ No

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

Complete if applicable to your current health condition: ☐ Personal Injury ☐ Auto Accident ☐Workers Compensation

If you have consulted an attorney, regarding the above, please provide your attorney's name and address:

Name: _____ Phone: _____

Address: _____

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

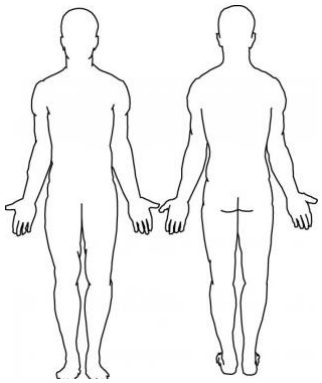
Mark your pain on the scale of 1 to 10: At Rest: No Pain ☺ 1 2 3 4 5 6 7 8 9 10 ☹ Extreme Pain

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.)

Allergies

☐ Pollen ☐ Dust ☐ Ragweed ☐ Latex ☐ Animals

Other:_____

Vitamin/Herbs/Minerals/Supplements: _____

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.)

_____Gastro-Intestinal (Acid Reflux, Ulcers, Gall Bladder, IBS, Etc.)

_____Ears, Mouth, Nose, Throat (Hearing Loss, Sinus, Etc.)

_____Genitourinary (Male/Female Reproductive, Kidney, Bladder, Etc.)

_____Cardiovascular (Heart, High BP, High Cholesterol, Etc.)

_____Musculoskeletal (Breaks, Arthritis, Osteoporosis, Discs, Etc.)

_____Respiratory (Lungs, Breathing, Asthma, COPD, Etc.)

_____Skin (Rashes, Skin Cancer, Dryness, Psoriasis, Eczema, Hair, Etc.)

_____Neurological (Nerve Issues, Weakness, Numbness, Etc.)

_____Psychiatric (Anxiety, Depression, Bipolar, ADD/ADHD, Etc.)

_____Endocrine (Thyroid, Hormonal, Imbalances, Liver, 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