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: _____

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

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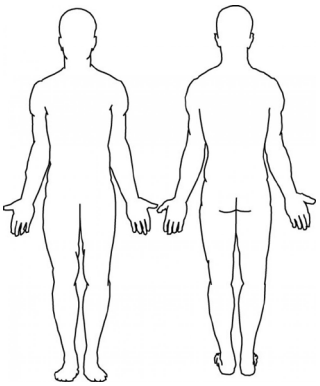
Type of pain:

□ 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.)
____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

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Other ancillary procedures, such as electric muscle stimulation or traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare," statistically less often then complications from taking a single aspirin tablet.

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Signature of Patient: _____ Date: _____