Lake Country Chiropractic

CONFIDENTIAL PATIENT HEALTH COMPLAINT FORM

Name_____Nickname_____Today's Date_____

Address_____ City_____ State _____

Zip_____ Home Phone(_____)_____ Cell Phone(_____)_____

May we e-mail you? Y / N E-Mail Address _____

Age____ Birth date____/_____/____ Sex: M / F Height_____ Weight _____ Marital Status S / M / D / W

S.S. # _____-_____-_____ How did you hear about our office?_____

Employer Name_____ Employer Phone (_____)_____

Employer Address _____ City and Zip _____

Contact in Case of Emergency_____ Phone (_____)_____

What is your chief complaint?_____

When did this complaint begin? (date)_____

What caused this problem?_____

Complaints/Disturbances: ☐ come and go ☐ came on gradually ☐ came on suddenly

Symptoms are BETTER in: ☐ A.M. ☐ P.M. Symptoms are WORSE in: ☐ A.M. ☐ P.M.

Symptoms have persisted for: ☐ Hours ☐ 1 Day ☐ Days ☐ Weeks ☐ Months ☐ Years

Symptoms developed from: ☐ A work injury ☐ An auto accident ☐ Other accident ☐ N/A

What activities make conditions WORSE?_____

What activities make conditions BETTER?_____

Have you ever had this condition/problem before? ☐ Yes ☐ No

If yes, when?_____

Describe other complaints. Please be specific:

Involving neck and head:_____

Involving mid-back/shoulders/arms &hands:_____

Involving low back/hips/legs & feet:_____

Indicate ability to perform the following activities: use codes U=unable P= Painful L= Limited N= Normal

_____coughing	_____lying on back	_____sleeping
_____sneezing	_____lying flat on stomach	_____stooping
_____bending forward	_____lying on side with knees bent	_____gripping
_____turning over in bed	_____climbing	_____pushing
_____walking short distances	_____kneeling	_____pulling
_____standing more than one hour	_____balancing	_____reaching
_____sitting at a table	_____dressing self	_____sexual activity

Family History:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE	HIGH B.P.
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐

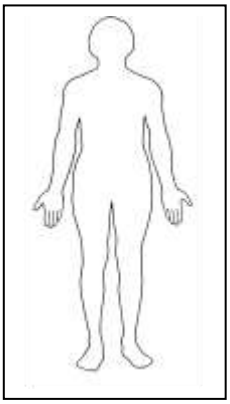
Women: Are you pregnant? Yes No Unsure/Possibly
What was the first day of your last menstrual cycle? (date) _____

Shade and code areas to indicate location of pain or discomfort:

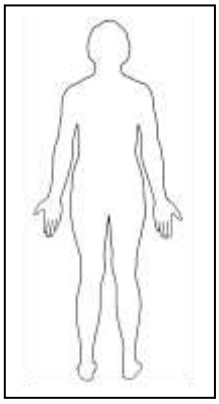
Use Codes:

Numbness	- - - - - - - - -
Pins & Needles	+ + + + + +
Burning	X X X X X X
Dull Ache	o o o o o o
Stabbing Pain	/ / / / / / / / /

FRONT



BACK



Check any of the following diseases you have had:

☐Aids	☐Malaria	☐Chicken Pox	☐Alcoholism	☐Appendicitis
☐Tuberculosis	☐Diabetes	☐Venereal Infection	☐Scarlet Fever	☐Whooping Cough
☐Cancer	☐Arthritis	☐Anemia	☐Heart Disease	☐Epilepsy
☐Measles	☐Goiter	☐Mental Disorder	☐Pneumonia	☐Mumps
☐Influenza	☐Lumbago	☐Rheumatic Fever	☐Eczema	☐Polio

Check any of the following problems you have or have had in the past 6 months:

Muscles & Joints
☐Low Back Pain
☐Pain Betwn Shoulders
☐Neck Pain/Stiffness
☐Arm/Elbow/Wrist Pain
☐Walking Problems
☐Difficulty Chewing
☐Clicking Jaw
☐Leg/Knee/Foot Pain
☐Hip Pain
☐Pain in Tailbone

Eye,Ear,Nose & Throat
☐Vision Problems
☐Dental Problems
☐Sore Throat
☐Earaches
☐Hearing Difficulty
☐Stuffed Nose
☐Ringing in Ears
☐Nose Bleeds
☐Sinus Trouble
☐Swollen Glands

Nervous System
☐Nervousness
☐Numbness
☐Paralysis
☐Dizziness
☐Confusion
☐Depression
☐Fainting
☐Convulsions
☐Cold Extremities

Hearts & Lungs
☐Wheezing
☐Chest Pain
☐Asthma
☐Short Breath
☐High Blood Pressure
☐Low Blood Pressure
☐Irregular Heart Beat
☐Heart Surgery
☐Lung Congestion
☐Coughing
☐Spitting Blood
☐Varicose Veins
☐Ankle Swelling
☐Bronchitis

General Problems
☐Fatigue
☐Night Sweats
☐Frequent Colds
☐Loss of Sleep
☐Fever
☐Headaches
☐Weakness

Stomach/Intestines
☐Poor Appetite
☐Excessive Appetite
☐Excessive Thirst
☐Nausea
☐Vomiting
☐Diarrhea
☐Hemorrhoids/Piles
☐Liver Trouble
☐Gall Bladder Problems
☐Weight Trouble
☐Stomach Cramps
☐Stomach Pain
☐Gas/Bloating
☐Heartburn
☐Black/Bloody Stool
☐Colitis

Kidney/Bladder
☐Painful Urination
☐Excessive Urine
☐Discolored Urine
☐Bedwetting
☐Bad Urine Control

Men
☐Prostate Pain
☐Impotence
☐Infertility

Women
☐Menses Irregular
☐Menstrual Cramps
☐Vaginal Pain
☐Breast Lumps
☐Pain During Sex
☐Infertility
☐Miscarriage

What type of activities do you do at work?_____

What recreational or exercise activities are you involved in?_____

_____

What type of foods do you eat most often?_____

Have you ever been treated by a chiropractor?_____When?_____

Last X-Rays or MRI_____ Reason:_____

Last Doctor visit_____ Reason:_____

Have you seen any other doctor for your present condition? ☐ Yes ☐ No

If yes, please give doctor's name and specialty:_____

Do you have any allergies?_____

Please list any surgeries you have had (include when and what they were for)._____

_____

Please list any medications, vitamins, and supplements that you are currently taking and what they are for (including any prescription medications that you take as well as birth control pills and "over the counter" medications and pain relievers)._____

_____

Habits: ☐ Smoking Packs per Day_____ ☐ Alcohol Drinks per Day_____
☐ Coffee Cups per Day_____ ☐ Soda Cans per Day_____

Payment Information

Clinic policy requires that payment arrangements be made on the first visit if any balance is due. Our overall corporate policy is that finances do not become a barrier for you to get the care that you need. Please indicate below how you will be taking care of this account:

☐ Health Insurance ☐ Cash/Check/Credit Card ☐ Auto Insurance
☐ Medicare ☐ Medicaid/T19 ☐ Worker's Compensation

Please give any insurance information you may have and a copy of your insurance card to our Front Desk Assistant. We will be happy to determine coverage for you.

Consent to Treat

The primary treatment used by doctors of chiropractic is the spinal adjustment. We will use primarily that procedure to treat you. The doctor may use his or her hands or a mechanical device upon your body in such a way as to move, or adjust your joints. By signing below you state that you are willing to undergo a chiropractic examination, x-rays of your spine (if indicated), and chiropractic treatment as may be outlined by the doctor after examination has been done.

Signature_____ Date_____

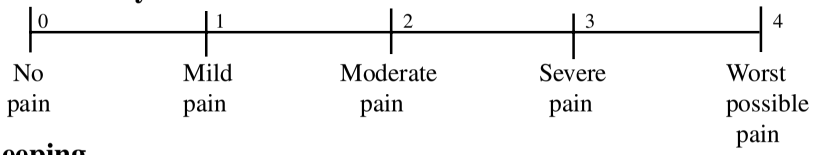
Consent to treat minor child _____ Relation_____

Functional Rating Index

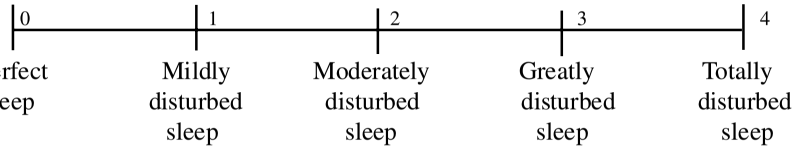
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

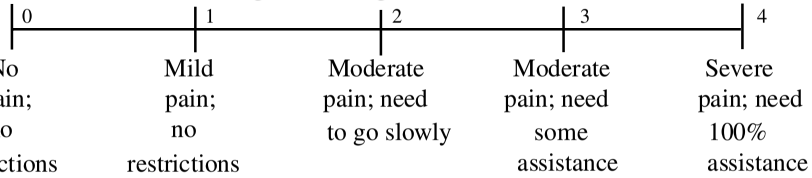
1. Pain Intensity



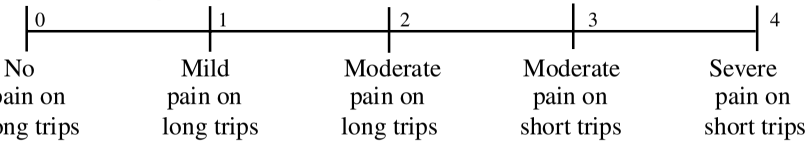
2. Sleeping



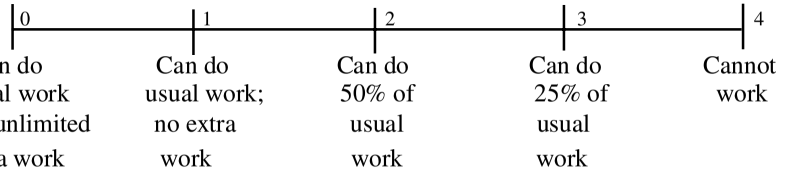
3. Personal Care (washing, dressing, etc.)



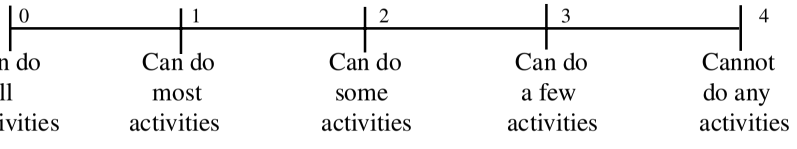
4. Travel (driving, etc.)



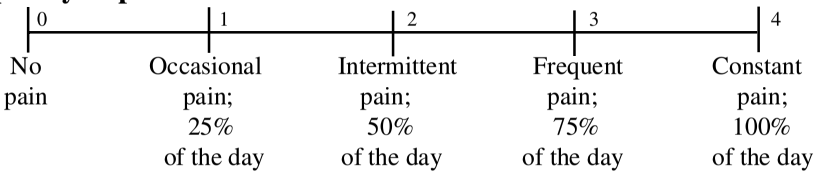
5. Work



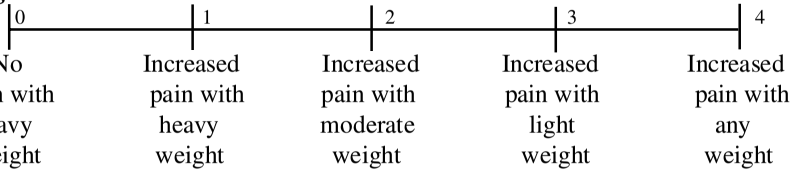
6. Recreation



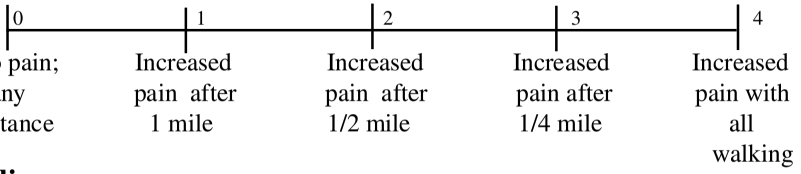
7. Frequency of pain



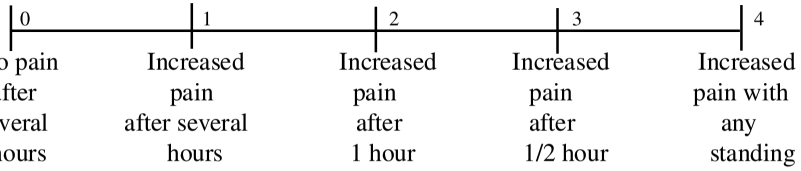
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Lake Country Chiropractic
864 Rose Drive
Hartland, WI 53029
(262) 367-4523
www.lakecountychiro.com

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices. I understand a copy of the Notice of Privacy Practices is available in the clinic and on the clinic website.

Name _____ Birthdate _____

Signature _____ Date _____

Lake Country Chiropractic
X-Ray Consent Form

Patient: _____ DOB: _____ Date: _____

CONSENT TO X-RAY
I understand the doctor may feel that x-rays will be needed in order to diagnose my condition and administer treatment. I authorize diagnostic x-rays to be performed by the doctor or certified staff at Lake Country Chiropractic.

_____

Patient Signature Date

FEMALE CONSENT
This is to certify that, to the best of my knowledge, I am not pregnant. Lake Country Chiropractic doctor and certified staff have my permission to perform diagnostic x-rays. I understand that radiation can be harmful to an unborn fetus.

_____

Female Patient Signature Date

CONSENT TO X-RAY A MINOR
I understand the doctor may feel that x-rays will be needed in order to diagnose and treat the patient. As the parent or guardian of the patient, I authorize the performance of diagnostic x-rays by the doctor or certified staff on the above named minor.

_____

Parent/Guardian Signature Date