Lake Wissota
Family Chiropractic
"Care for the whole family!"

## New Patient Application

Name: _____ Middle Initial ___ Age: _____ Today's Date: ____/____/ ____

Address: _____
Residence and mailing City State Zip Code

Home Telephone ( ) _____ Work ( ) _____ Cell ( ) _____

Email address for our newsletter and updates _____
Male [] Female []
Social Security #_____ Birthday _____

Occupation/Employer_____

Single [] Married [] Divorced [] Widowed [] Number of children_____

Name of Insured_____ Insured DOB_____

Appointment reason(s):
_____

Emergency Contact: name_____ relation_____
Home Telephone ( ) _____ Work ( ) _____ Cell ( ) _____

Who may we thank for referring you to our office?
_____

## Chiropractic care

The basis behind chiropractic care is that "subluxation" (misalignment) can be caused by physical, emotional, or chemical stress to the body. This causes irritation or interference to the nervous system. Many times pain is the last symptom to appear, so many problems are not recognized until they become more severe. The first subluxation can occur as early on as during the birthing process.

_____

**Childhood History-Birth to age 17**

Yes No Unsure Explain

Did you have and childhood illnesses? (chicken pox, mumps etc.) [] [] [] _____
Yes No Unsure Explain

| | | | | |
|---|---|---|---|---|
| Did you have any serious falls or injuries as a child ? | [] | [] | [] | _____ |
| Did you play youth sports? | [] | [] | [] | _____ |
| Did you take/use and drugs? | [] | [] | [] | _____ |
| Did you have any surgery? | [] | [] | [] | _____ |
| Have you fallen/jumped from a height over three feet? | [] | [] | [] | _____ |
| Were you involved in any motor vehicle accidents? | [] | [] | [] | _____ |
| Was there any prolonged use of medicine (antibiotics, inhaler) | [] | [] | [] | _____ |
| Did you suffer any other physical or emotional traumas | [] | [] | [] | _____ |
| Were you vaccinated? | [] | [] | [] | _____ |
| As a child were you under regular chiropractic care? | [] | [] | [] | _____ |

**Adult Health History-18 to present**

| | Yes | No | Unsure | Explain (how much?) |
|---|---|---|---|---|
| Do/did you drink caffeine? | [] | [] | [] | _____ |
| Do/did you use tobacco? | [] | [] | [] | _____ |
| Do/did you drink alcohol? | [] | [] | [] | _____ |
| Do/did Recreational drugs | [] | [] | [] | _____ |
| Have you been in any accidents? | [] | [] | [] | _____ |
| Have you had any surgery? | [] | [] | [] | _____ |
| Do/did you play any adult sports? | [] | [] | [] | _____ |

On a scale of 1-10 describe your stress level (0=none/10=extreme)
Occupational_____ Personal_____

## Current Condition

Briefly describe your current
symptoms/condition_____
_____

Was injury or pain due to Home [], Work [], or Auto Accident []?

The pain you are experiencing is [] Sharp [] Dull [] Comes and goes [] Constant [] Travels
What makes symptoms worse _____
What makes them better _____

It interferes with [] Work [] Sleep [] Walking [] Sitting [] Standing [] Hobbies [] Leisure

On a scale of 1(minimal)-10(worst possible pain), my pain is_____/10

Other doctors seen for this condition:
Chiropractor_____ Did it help? _____
Medical doctor_____ Did it help? _____
Other_____ Did it help?_____

Did they do any imaging (x-ray, CT, MRI) or lab work? _____

List any medication including birth control medication or natural supplements or vitamins you are taking and why:

_____
_____
_____

## Review of Systems

Have you had any *past* or *present* health concerns with the following? If yes, please list dates and explain.

| | Yes | No | Unsure | Explain |
|---|---|---|---|---|
| 1. Headache | [] | [] | [] | _____ |
| 2. Eyes | [] | [] | [] | _____ |
| 3. Ears | [] | [] | [] | _____ |
| 4. Nose/Sinus | [] | [] | [] | _____ |
| 5. Throat | [] | [] | [] | _____ |
| 6. Heart/Circulation | [] | [] | [] | _____ |
| 7. Lungs | [] | [] | [] | _____ |
| 8. Thyroid | [] | [] | [] | _____ |
| 9. Digestion/Stomach or bowels | [] | [] | [] | _____ |
| 10. Diabetes | [] | [] | [] | _____ |
| 11. Urination/bladder | [] | [] | [] | _____ |
| 12. Reproduction/Sexual Function | [] | [] | [] | _____ |
| 13. Mental health | [] | [] | [] | _____ |
| 14. Skin | [] | [] | [] | _____ |
| 15. Numbness/Tingling | [] | [] | [] | _____ |
| 16. Neuromusculoskeletal | [] | [] | [] | _____ |
| 17. Back/Neck/Arthritis | [] | [] | [] | _____ |

## Family History (parents, siblings, grandparents)

1. Heart, BP, Cholesterol problems_____
2. Diabetes_____
3. Cancer_____
4. Neurologic_____
5. Thyroid_____
6. Back/Neck/Arthritis_____

*These statements are accurate to the best of my knowledge.*

_____ _____

Signed date

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