Wissota Chiropractic

HEALTH RECORD

PATIENT

DATE: _____

NAME: _____

SS#: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

EMAIL: _____

(STATEMENTS WILL BE SENT VIA EMAIL)

HOME PHONE: _____ CELL PHONE: _____

BIRTHDATE: _____ ❑ MALE ❑ FEMALE

EMPLOYER: _____

EMPLOYER CITY/STATE/ZIP: _____

WORK PHONE: _____

POSITION TITLE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE: _____

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____

POLICY #: _____

BIRTHDATE OF PRIMARY INSURANCE HOLDER: _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE?

❑ YES ❑ NO

SECONDARY INSURANCE COMPANY: _____

POLICY #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with provided insurance company and assign directly to Dr. Michelle Tell Peck all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE: _____

DATE: _____

ACCIDENT INFORMATION

IS THIS CONDITION DUE TO AN ACCIDENT? ❑ YES ❑ NO DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: ❑ AUTO ❑ WORK ❑ HOME ❑ OTHER

TO WHOM HAVE YOU MADE A REPORT ABOUT THIS ACCIDENT: ❑ AUTO INSURANCE ❑ EMPLOYER ❑ WORKER COMP. ❑ OTHER

ATTORNEY'S NAME (IF APPLICABLE): _____

PLEASE ASK FOR ADDITIONAL ACCIDENT INFORMATION FORM

HEALTH HISTORY

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION (ALL THAT APPLY):

❑ MEDICATIONS ❑ SURGERY ❑ PHYSICAL THERAPY ❑ CHIROPRACTIC SERVICES ❑ NONE ❑ OTHER

NAME OF OTHER DOCTOR(S) WHO HAVE TREATED YOU FOR THIS CONDITION: _____

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❑ YES ❑ NO WHEN: _____

WHAT CHIROPRACTIC TECHNIQUE DO YOU PREFER, IF ANY? _____

(PLEASE COMPLETE BACK SIDE)

HEALTH HISTORY

BRIEFLY DESCRIBE YOUR SYMPTOMS?_____

SYMPTOMS BEGAN ON: _____

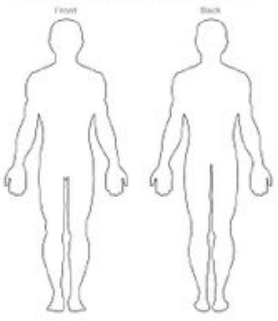
HOW DID YOUR SYMPTOMS START? _____

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (SEVERE PAIN): _____

HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS?_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ❑ YES ❑ NO ❑ UNKNOWN

PLACE AN "X" ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING.



TYPE OF PAIN: ❑ SHARP ❑ DULL ❑ THROBBING ❑ NUMBNESS ❑ ACHING ❑ SHOOTING ❑ BURNING

❑ TINGLING ❑ CRAMPS ❑ STIFFNESS ❑ SWELLING ❑ _____

HOW MUCH HAS THIS INTERFERED WITH YOUR LIFE FROM 1 (NOT AT ALL) TO 5 (EXTREMELY)? _____

DOES IT INTERFERE WITH YOUR: ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ RECREATION ❑ SITTING ❑ STANDING ❑ WALKING ❑ BENDING ❑ LYING

INSTRUCTIONS: *Please check each of the diseases or conditions that you have now or had had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ AIDS/HIV	❑ BULIMIA	❑ GONORRHEA	❑ MEASLES	❑ POLIO	❑ TONSILLITIS
❑ ALCOHOLISM	❑ CANCER	❑ GOUT	❑ MIGRAINE HEADACHES	❑ PROSTATE PROBLEM	❑ TUBERCULOSIS
❑ ALLERGY SHOTS	❑ CATARACTS/ GLAUCOMA	❑ HEART DISEASE	❑ MISCARRIAGE	❑ PROSTHESIS	❑ TUMORS, GROWTHS
❑ ANEMIA	❑ CHEMICAL DEPENCENCY	❑ HEPATITS	❑ MONONUCLEOSIS	❑ PSYCHIATRIC CARE	❑ TYPHOID FEVER
❑ ANOREXIA	❑ CHICKEN POX	❑ HERNIA	❑ MULTIPLE SCLEROSIS	❑ RHEUMATOID ARTHRITIS	❑ ULCERS
❑ APPENDICITIS	❑ DIABETES	❑ HERNIATED DISC	❑ MUMPS	❑ RHEUMATIC FEVER	❑ VAGINAL INFECTIONS
❑ ARTHRITIS	❑ EMPHYSEMA	❑ HERPES	❑ OSTEOPOROSIS	❑ SCARLET FEVER	❑ VACCINE REACTIONS
❑ ASTHMA	❑ EPILEPSY	❑ HIGH BLOOD PRESSURE	❑ PACEMAKER	❑ STD'S	❑ WHOOPING COUGH
❑ AUTISM/SPECTRUM DISORDERS	❑ FERTILITY CHALLENGES	❑ HIGH CHOLESTEROL	❑ PARKINSON'S DISEASE	❑ STROKE	❑
❑ BLEEDING DISORDERS	❑ FRACTURES	❑ KIDNEY DISEASE	❑ PINCHED NERVE	❑ SUICIDE ATTEMPT	❑
❑ BRONCHITIS	❑ GOITER	❑ LIVER DISEASE	❑ PNEUMONIA	❑ THYROID PROBLEMS	❑

ARE YOU PREGNANT? ❑ YES ❑ NO IF YES, DUE DATE: _____

EXERCISE:	WORK ACTIVITY:	HABITS:
❑ NONE	❑ SITTING	❑ SMOKING PACKS/DAY _____
❑ MODERATE	❑ STANDING	❑ ALCOHOL DRINKS/WEEK _____
❑ DAILY	❑ LIGHT LABOR	❑ COFFEE/CAFFEINE DRINKS CUPS/DAY _____
❑ HEAVY	❑ HEAVY LABOR	❑ HIGH STRESS LEVEL REASON _____

INJURIES/SURGERIES YOU HAVE HAD:

	DESCRIPTIONS	DATES
INJURIES	_____	_____
BROKEN BONES/DISLOCATIONS	_____	_____
SURGERIES	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____