HealthWise
Family Chiropractic, P.A.

3803 Silver Lake Road Unit 100 • St Anthony MN, 55421
Phone: 612-789-1700
Fax: 612-788-9011

Today's Date _____

Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____ Work Phone _____

Occupation _____ Employed by: _____

Email Address_____

Do you prefer we contact you by (please circle): ☐ All ☐ Email ☐ Cell ☐ Home ☐ Work

Marital Status: ☐ S ☐ M ☐ W ☐ D Number of Children _____

Name of Spouse _____ Phone _____

Emergency Contact _____ Phone _____

How did you hear about us? ☐ Drove by ☐ Our Website ☐ Bus Bench ☐ Insurance Co ☐ Phonebook/Online

Referral (please tell us whom so we may thank them!):_____

Other (please specify): _____

Current Health Condition

Reason for visit:_____

When did it begin?:_____

Briefly describe your current symptoms:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching

☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Shooting _____ (Location)

Rate the severity of your pain (0= no pain, 10 = unbearable pain!) _____

Since your problem began, is the pain? ☐ Increasing ☐ Decreasing ☐ About the same

What treatment have you already received for your condition?

☐ Chiropractic ☐ Medical Doctor ☐ Medication ☐ Physical Therapy ☐ Surgery ☐ Other

Name of other treating practitioner _____

Daily Habits

How often do you exercise per week? ☐ None ☐ 1-2 days ☐ 3-4 days ☐ 5-7 days

What do your daily work habits, include/hours per day? ☐ Sitting ____ ☐ Standing ____

☐ Light Labor ____ ☐ Heavy Labor ____ ☐ Computer/Desk Work ____

Occupational stresses? (please specify):_____

Habits: Caffeine (type/use)_____ Fruits/Veggies (servings/day) _____

Alcohol (type & drinks/week)_____ Cigarettes(pack/day)_____

Medications, Vitamins and/or Supplements you are currently taking:_____

_____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Allergy Shots	☐ Anemia	☐ Anorexia	☐ Appendicitis	☐ Arthritis
☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump	☐ Bronchitis	☐ Bulimia	☐ Cancer
☐ Cataracts	☐ Chemical Depend	☐ Chicken Pox	☐ Concussion	☐ Depression	☐ Diabetes
☐ Digestive Disorders	☐ Dizziness	☐ Emphysema	☐ Epilepsy	☐ Fractures	☐ Glaucoma
☐ Goiter	☐ Gout	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herniated Disc
☐ Herpes/Cold Sores	☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraines	☐ Miscarriage	☐ Mononucleosis	☐ Multiple Sclerosis	☐ Mumps	☐ Osteoporosis
☐ Pacemaker	☐ Parkinson's	☐ Pneumonia	☐ Prostate	☐ Prosthesis	
☐ Rheumatoid Arthritis	☐ Rheumatic Fever	☐ RSV	☐ Stroke	☐ Suicide Attempt	☐ Thyroid Problems
☐ Tonsillitis	☐ Tumors/Growths	☐ Ulcers	☐ Vaginal Infect	☐ Whooping Cough	☐ Other

Have you been treated for any other health condition in the last year? Yes No
If Yes, please explain:_____

(Women) Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking Birth Control Pills? ☐ Y ☐ N

Allergies? _____

List any surgeries you have had and dates they occurred:

_____

_____

Health and Medical Release Information:

I,_____, give permission to Dr. Blomberg, her staff, associates, and employees of the HealthWise Family Chiropractic, to share private and medical information with my medical doctor,_____, as well as his staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Blomberg and her staff.

Medical Doctor Information:

Clinic Name:_____ City:_____

To the best of my knowledge, the information provided is complete and correct.
I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or Insurance coverage.

Signature:_____ **Date:**_____