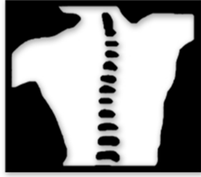


# RADERMACHER CHIROPRACTIC

N112W16260 Mequon Rd, PO Box 312, Germantown, WI 53022
Phone: 262-255-7700 Fax: 262-255-0581

**Confidential Patient Health Record**

Date: ____________________

***Patient Information:***

Name: ________________________________ Birth Date: ____________________ Phone: ___________________________

Gender: **M F** Race: _____________ Ethnicity: **Hispanic/Latino Not Hispanic/Latino**

Preferred Language: _________________ Address: ___________________________________________________________

City: __________________________________ State: __________________________ Zip: ____________________________

Social Security #: ____________________ Email: ______________________________________________________________

Employment Status: **Working / Retired / Unemployed / Part-Time Student / Full-Time Student**

Occupation: ________________________ Employer: ____________________________________________________________

Marital Status: **Single / Married / Widowed / Divorced / Separated**

Spouse/Parent's Name: ______________________________________ Occupation: ___________________________________

Personal Health Insurance Carrier: ____________________________ Policy Number: _________________________

Insured Person's Name: _________________________________________________________________________________________

Name of Previous Chiropractor: _________________________________________________________________________________

Name of Medical Doctor: ________________________________________________________________________________________

Referred To This Office By: **Print Ad / Mailing / Search Engine / Other:** _______________________________

Name and Number of Emergency Contact: _________________________________________________________________________

Height: _____________ Weight: _____________

***Patient Condition:***

Reason(s) for visit:_________________________________________________________________________________________

Is this condition due to an accident? **YES / NO - Auto / Work / Home / Other** Date:_____________

When did your symptoms appear?______________________________ Is this condition getting worse? **YES / NO**

Is it constant or does it come and go? ________________ Is it worse with rest or activity? _________________________

What do you think caused this problem? _______________________________________________________________________

Which best describes the character of your pain? **Dull / Sharp / Numb / Tingling / Burning**

Is the pain worse in the AM or PM? ______________________________

What treatments have you already received for your condition?

**None / Physical Therapy / Massage Therapy / Medication**

**Surgery / Chiropractic / Other:** _________________________

What activities are difficult/painful to perform?

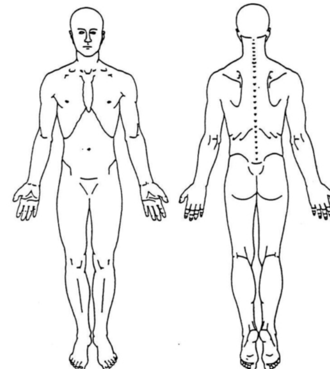
**Sit / Stand / Sit to Stand / Walk / Bend / Drive**

**Computer Work / Lay Down / Sleep / Other:**_______

_____________________________________________________________

_____________________________________________________________

Mark an "**X**" on the picture where you are experiencing symptoms:



***Pain Scale:*** **Rate your condition on a scale of 0 to 10**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pain Intensity | Mild Pain | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Severe Pain |
| Change In Pain | Improving | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Worsening |
| Lifting | No Effect | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Unable To Perform |
| Walking | No Effect | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Unable To Perform |
| Sitting | No Effect | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Unable To Perform |
| Standing | No Effect | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Unable To Perform |
| Sleeping | No Effect | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Unable To Perform |
| Traveling | No Effect | ☺ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ☹ Unable To Perform |

***Personal Health History:***

Have you had any surgeries? ____________________________________________

What medications are you currently taking and for what condition(s)? ____________________

____________________________________________________________

____________________________________________________________

Do you have any allergies? **YES / NO** List: ____________________________________

Are you pregnant? **YES / NO** Due Date: ________________

Please circle to indicate if you have experienced any of the following:

| | | | |
|---|---|---|---|
| Headaches | Heart Disease | Vision Problems | Concussion |
| Sinus Problems | Dizziness | Asthma | Digestive Problems |
| Nausea | Earaches | Poor Circulation | Cancer |
| Heart Problems | Diabetes | Hypertension | Stroke |
| Low back pain | Mid back pain | Neck pain | Arthritis |

Other, please specify: ____________________________________________

____________________________________________________________

***Social/Work History:***

Work Activity: **Sit / Stand / Computer Work / Light Labor / Heavy Labor / None**

Habits: Tobacco Use: Now? **YES / NO** Amount/Weekly_____ How long?_____ Years/Months

In the past? **YES / NO** Amount/Weekly______ How long?_____ Years/Months

Alcohol Use: Now? **YES / NO** Amount/Weekly______ How long?______ Years/Months

In the past? **YES / NO** Amount/Weekly______ How long?______ Years/Months

**All of the answers I have given are correct to the best of my knowledge, and I agree to continue with my evaluation at Radermacher Chiropractic at this time:**

____________________________________________________________

**Patient's Signature** **Date**

____________________________________________________________

**Signature of Parent or Legal Guardian** **Date**