RUBERT CHIROPRACTIC CLINIC

215 South Wales St., Hustisford, WI 53034 Ph: (920) 349-3233 W1185 McCrae Rd., Fall River 53932 Ph: (920) 484-6444

Confidential Patient Case History

Thank you for allowing us to address your health needs. The information on this questionnaire will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

ABOUT YOU: (Patient Information)

Name:(Last, First M.I.) _____What do you prefer to be called? _____

Address: _____ City_____ State _____ Zip _____

Home Phone # (_____) _____ Cell Phone # (_____) _____Text reminders: ☐Yes ☐No

Date of Birth _____-_____-_____Age _____ Gender **M F** Cell Phone Provider: _____

Employer _____ Occupation: _____

Where did you hear about Rubert Chiropractic? _____

SPOUSE CONTACT INFORMATION:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name:(Last, First M.I.) _____ Date of Birth _____-_____-_____

Phone: (_____) _____

ADDITIONAL EMERGENCY CONTACT INFORMATION (other than spouse):

Name:(First & Last) _____Relationship _____Phone(_____) _____

ELECTRONIC HEALTH RECORDS (EHR) INTAKE:(Please circle one in each line)

Preferred method of communication for patient reminders: Email Phone Mail

Preferred language: English Other: _____

Smoking Status: Every Day Smoker Occasional Smoker Former Smoker Never Smoked

Race: American Indian/Alaskan Native Asian African American White Native Hawaiian/Pacific Islander Other

Decline to Answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline to Answer

ABOUT YOUR CONDITION:

If this is an injury, check one of the following:☐ Work Related Injury *☐ Automobile Accident *☐Other Injury/Fall *

**Please inform the front desk, as additional paperwork and appointment time may be required.*

What are your primary complaint/symptoms? _____

Date symptoms appeared _____-_____-_____ Have you had similar symptoms in the past? **Y N**

Additional complaints or symptoms? _____

Doctors you have seen for this condition: Dr. _____ Phone: (_____) _____

Doctor's Address _____

Have you ever seen a chiropractor in the past? Name: _____

Have x-rays been taken for the area of concern? **Y N** If yes, about how long ago? _____

FAMILY HEALTH HISTORY:

Many health problems are a result of hereditary conditions.Therefore, information about your family will give us a better understanding of your total health picture. Please include blood relatives only: Parents, siblings or children

Name	Relation	Past/Present Health Problems

GENERAL HEALTH HABITS:

What pharmacy do you use? _____ Location: _____

Are you currently taking any medications? ☐ Yes ☐ No*(If pharmacy info is given, medications you are taking can be left blank)*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ☐ Yes ☐ No/Unknown

Medication Name	Reaction	Onset Date	Additional Comments

Vitamins/Supplements: _____

Coffee _____ cups/day Soda _____ drinks/day Alcohol _____ drinks/day Tobacco _____ packs/day

How many hours do you: Commute to work? _____ Work?_____ Exercise?_____ Sleep? _____

Do you eat a well-balanced diet? **Y N** ***Females only:*** *Are you pregnant?* **Y N** *Nursing?* **Y N**

YOUR HEALTH HISTORY:

Please list/date any Surgeries: _____

Please list/date any major accidents, falls or other trauma: _____

Do you have any difficulty with any of the following: (please circle)

Alcoholism	Diabetes	High Blood Pressure	Psoriasis
Allergies	Dizziness	Hypoglycemia	Rheumatoid Arthritis
Anemia	Eczema	Indigestion	Sciatica
Arthritis	Emphysema	Kidney Problems	Sinus Trouble
Asthma	Epilepsy	Liver Trouble	Scoliosis
Cancer	Fatigue	Lumbago	Sleeplessness
Chronic Back Pain	Gall Bladder Problems	Menstrual Cramps (PMS)	Spine Trouble
Chronic Neck Pain	Gout	Mental Disorder	Stomach Trouble
Cold Hands/Feet	Hardening of Arteries	Multiple Sclerosis	Strokes
Colds/Infection	Headaches	Miscarriages	Thyroid Trouble
Colon Trouble	Hearing Problems	Nervousness	Ulcers
Constipation	Heart Disease	Pneumonia	Varicose Veins
Depression	Heart Problems	Prostate Problems	

Do you have any pain or numbness in the following areas? (Use**R** for Right, **L** for Left, and **B** for Both)

Head _____	Mid Back _____	Arm _____	Legs _____
Chest _____	Low Back _____	Wrist _____	Knees _____
Stomach _____	Shoulder _____	Hand _____	Ankles _____
Neck _____	Elbow _____	Hips _____	Feet _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my health or insurance status.

Signature _____ Date _____