CORNERstone
CHIROPRACTIC & WELLNESS

153 S Main St Shawano, WI 54166

**Security Health Plan** Confidential Patient Health Record

## WELCOME TO WELLNESS – WE'RE GLAD YOU ARE HERE

Name: _____ Age: _____ Today's Date: _____

Mailing Address: _____City: _____

St: ____ Zip: _____

Phone (home): _____ (cell):_____ Preferred Contact: Home / Cell / Either

SSN#:_____ Birth date: _____/_____/_____ No. of Children: _____

E-Mail: _____ I Am: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widow

Occupation/Employer/School: _____

Emergency Contact/Relationship: _____Phone: _____

How did you here about us? ☐ Location ☐ Doctor ☐ Internet ☐ Ins Co Referral ☐ Friend or Family Member

Who can we thank for referring you? _____

We promise to treat you with respect, compassion, and understanding.

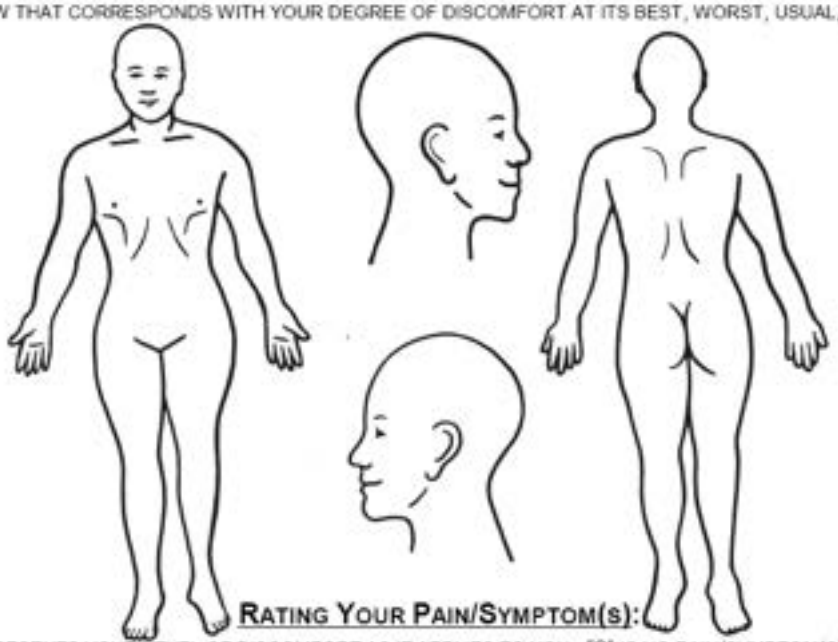
## ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

# HISTORY OF PRESENT ILLNESS / INJURY

### CHIEF COMPLAINT(S)

FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION USING THE APPROPRIATE SYMBOLS FROM THE LEFT. CIRCLE THE NUMBER BELOW THAT CORRESPONDS WITH YOUR DEGREE OF DISCOMFORT AT ITS BEST, WORST, USUAL, & RIGHT NOW.

X X X BURNING PAIN
( ( ( ( ACHING PAIN
0 0 0 PINS & NEEDLES
- - - - NUMBNESS
: : : : SHARP PAIN



**PLEASE COMPLETE:**

____ CONSTANT
____ COME & GO

____ GETTING BETTER
____ GETTING WORSE
____ STAYING SAME

| BETTER: | | WORSE: |
|---|---|---|
| ____ | AM | ____ |
| ____ | MID-DAY | ____ |
| ____ | PM | ____ |

**RATING YOUR PAIN/SYMPTOM(S):**

ENTER THE NUMBER THAT BEST REPRESENTS YOUR LEVEL OF DISCOMFORT AS IT APPLIES TO YOU. "0" IS NO PAIN/SYMPTOM(S). "100" IS INTOLERABLE.

| NECK (RATE 0-100): | MID BACK (0-100): | LOW BACK (0-100): | _____: | _____: | _____: |
|---|---|---|---|---|---|
| NOW: _____ | NOW: _____ | NOW: _____ | NOW: _____ | NOW: _____ | NOW: _____ |
| BEST: _____ | BEST: _____ | BEST: _____ | BEST: _____ | BEST: _____ | BEST: _____ |
| WORST: _____ | WORST: _____ | WORST: _____ | WORST: _____ | WORST: _____ | WORST: _____ |
| USUAL: _____ | USUAL: _____ | USUAL: _____ | USUAL: _____ | USUAL: _____ | USUAL: _____ |

## UNDERSTANDING YOUR HEALTH HISTORY

Please check (√) all symptoms you have ever had, even if they do not seem related to your current condition.

| | | |
|---|---|---|
| □ Headaches | □ Kidney/Bladder | □ Hepatitis |
| □ Pins and Needles in arms | □ Neurological | □ HIV |
| □ Dizziness | □ Osteoporosis | □ Psoriasis/Eczema |
| □ Numbness in fingers | □ Liver Disease | □ Anemia |
| □ Fatigue | □ Bleeding Disorder | □ Arthritis |
| □ Sleeping problems | □ Diabetes | □ Accident - Major |
| □ Diarrhea | □ Thyroid | □ High Cholesterol |
| □ Cold Sweats | □ Alcohol or drug abuse | □ Lung Disease |
| □ Mood Swings | □ Mental Health | □ Stomach Ulcer |

Family Health Profile:
At Cornerstone Chiropractic we are not only interested in your health, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

Have you ever:

| | | | |
|---|---|---|---|
| Bought bottled water: | □ Yes, currently | □ Yes, in the past | □ No, never |
| Belonged to a health club / gym? | □ Yes, currently | □ Yes, in the past | □ No, never |
| Consumed Vitamins or supplements: | □ Yes, currently | □ Yes, in the past | □ No, never |

## YOUR HEALTH PROFILE

**why this section is important:** As a Wellness Center, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Please answer the following questions the best you can:

## YOUR CHILDHOOD YEARS:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Did you have any childhood injures? | Yes | No | Unsure | Did you suffer any other traumas (physical or emotional) | Yes | No | Unsure |
| Did you have any serious falls as a child? | Yes | No | Unsure | Were you vaccinated? | Yes | No | Unsure |
| Did you play youth sports? | Yes | No | Unsure | As a child, were you under regular Chiropractic care? | Yes | No | Unsure |
| Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed , trees) | Yes | No | Unsure | Did you have any surgery? | Yes | No | Unsure |
| Was there any prolonged use of medicine such as antibiotics or an inhaler? | Yes | No | Unsure | Were involved in any other accidents as a child? | Yes | No | Unsure |
| Did you take /use any drugs? | Yes | No | Unsure | Did you have a difficult or traumatic birth? | Yes | No | Unsure |

*You're almost done, just one more page!*

## PAST MEDICAL HISTORY - CONTINUED

☐ ☐ **DO YOU HAVE ANY ALLERGIES?** IF SO, TO WHAT? _____

☐ ☐ **LIST ANY PRESCRIPTION DRUGS, OVER THE COUNTER DRUGS, VITAMINS, AND/OR SUPPLEMENTS:** (USE MORE PAPER AS NEEDED.)

| PRODUCT / DRUG | REASON(S) | FREQUENCY | DOSAGE | HELPING? |
|---|---|---|---|---|
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |

☐ ☐ **HAVE YOU ATTEMPTED ANY OTHER SELF CARE REMEDIES TO ALLEVIATE YOUR CONDITION? (E.G. TOPICAL OINTMENTS OR HOME MEDICAL EQUIPMENT SUCH AS BRACES/SUPPORTS, CERVICAL PILLOW, LOW BACK SUPPORT BELT, STRETCHING, EXERCISING, ETC.) IF YES, WHAT?**

_____

☐ ☐ **DESCRIBE ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS, AND/OR SURGERIES:** (USE MORE PAPER AS NEEDED.)

| DATE | DR. NAME | CONDITION(S) | RESULTS |
|---|---|---|---|
| | | | ☐ COMPLETE RECOVERY ☐ COMPLICATIONS |
| | | | ☐ COMPLETE RECOVERY ☐ COMPLICATIONS |
| | | | ☐ COMPLETE RECOVERY ☐ COMPLICATIONS |

# SOCIAL HEALTH HISTORY

GENDER: ☐ MALE ☐ FEMALE STUDENT: ☐ PART-TIME ☐ FULL-TIME ☐ SCHOOL: _____

OCCUPATION: _____ HRS PER WEEK : _____ YRS ON JOB: _____ YRS WITH EMPLOYER: _____

RECREATIONAL ACTIVITIES / HOBBIES: _____

YES NO

☐ ☐ DO YOU EXERCISE? HOW OFTEN? _____ IN WHAT WAY? _____

☐ ☐ ARE YOU A SMOKER? HOW MUCH? _____

HOW MUCH WATER DO YOU DRINK? _____

☐ ☐ DO YOU CONSUME CAFFEINE? HOW MUCH & HOW OFTEN? _____

☐ ☐ DO YOU CONSUME ALCOHOL? HOW MUCH & HOW OFTEN? _____

# FAMILY HEALTH HISTORY

**LIST ANY CURRENT OR PAST HEALTH CONDITIONS OF YOUR FAMILY MEMBERS. OR IF DECEASED, AT WHAT AGE AND FROM WHAT?**

MOTHER: _____

FATHER: _____

BROTHERS/SISTERS: _____ HOW MANY? _____

CHILDREN: _____ HOW MANY? _____

# SYSTEM REVIEW QUESTIONS

**HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS NOW OR IN THE PAST?** (PLEASE MARK Y FOR YES OR N FOR NO IN EACH OF THE FOLLOWING:)

1. ____ **EYES** (GLASSES, CONTACTS, CATARACTS, GLAUCOMA, ETC.)
2. ____ **EARS, MOUTH, NOSE, THROAT** (HEARING LOSS, SINUS, ETC.)
3. ____ **CARDIOVASCULAR** (HEART, HIGH B.P., HIGH CHOLESTEROL, ETC.)
4. ____ **RESPIRATORY** (LUNGS, BREATHING, ASTHMA, C.O.P.D., ETC.)
5. ____ **NEUROLOGICAL** (NERVE ISSUES, WEAKNESS, NUMBNESS, ETC.)
6. ____ **ENDOCRINE** (THYROID, HORMONAL IMBALANCES, LIVER, ETC.)
7. ____ **GASTRO-INTESTINAL** (ACID REFLUX, ULCERS, GALL BLADDER, I.B.S., ETC.)
8. ____ **GENITO-URINARY** (MALE/FEMALE REPRODUCTION, KIDNEYS, BLADDER, ETC.)
9. ____ **MUSCULOSKELETAL** (BREAKS, ARTHRITIS, OSTEOPOROSIS, DISCS, ETC.)
10. ____ **SKIN** (RASHES, SKIN CANCER, DRYNESS, PSORIASIS, ECZEMA, HAIR, ETC.)
11. ____ **PSYCHIATRIC** (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC.)
12. ____ **OTHERS**: _____

PLEASE DESCRIBE IN MORE DETAIL: _____

I certify that I, and /or my dependent(s), have insurance coverage with Security Health Plan and assign directly to Cornerstone Chiropractic & Wellness 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. Cornerstone Chiropractic & Wellness may use my health care information and may disclose such information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

**Signature** of Patient, Parent, Guardian or Personal Representative Please **Print Name** of Patient, Parent, Guardian or Personal Representative

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