CORNERstone
CHIROPRACTIC & WELLNESS

153 South Main Street, PO Box 376 Shawano, WI 54166

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 ☐ Widowed

Employer: _____Occupation:_____

Emergency Contact/Relationship: _____Phone: _____

How did you hear 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

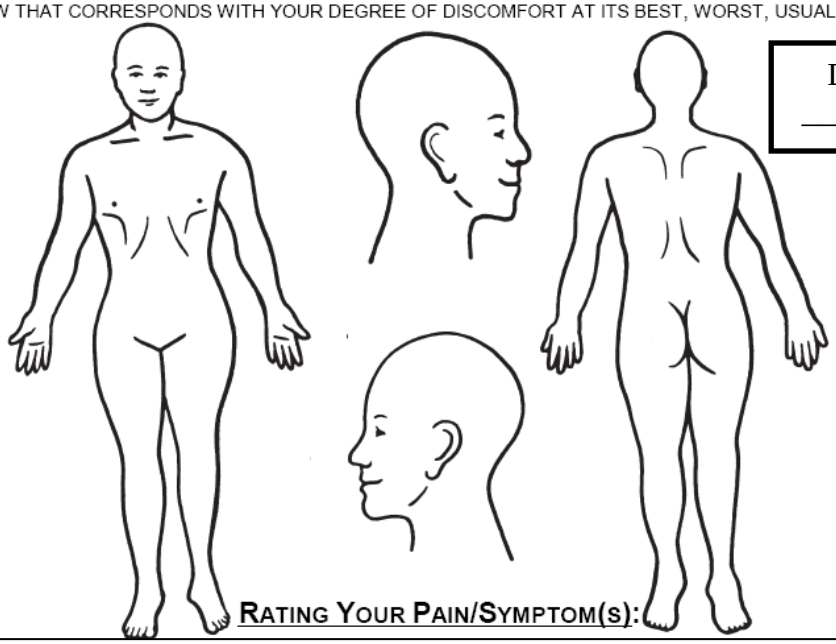
HISTORY OF PRESENT ILLNESS / INJURY

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

Date of injury: _____



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) "10" IS INTOLERABLE

NECK (RATE 0-10)	MID BACK (RATE 0-10)	LOW BACK (RATE 0-10)	_____ (RATE 0-10)	_____ (RATE 0-10)
NOW: _____	NOW: _____	NOW: _____	NOW: _____	NOW: _____
BEST: _____	BEST: _____	BEST: _____	BEST: _____	BEST: _____
WORST: _____	WORST: _____	WORST: _____	WORST: _____	WORST: _____
USUAL: _____	USUAL: _____	USUAL: _____	USUAL: _____	USUAL: _____

What Makes the Condition Better?

Head / Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

What Makes the Condition Worse?

Head / Neck _____
Mid Back _____
Low Back _____
Shoulder, Arm, Hand _____
Hip, Leg, Foot _____
Other _____

How Did It Occur? ☐ Work – Related Injury ☐ Auto Accident ☐ Other: _____

When Did They Begin? _____ Have You Missed Work? **Yes No** How Much? _____

Indicate Your Ability to Perform the Following Activities. Please Use the Following Codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

1. ____ Lying on Back
2. ____ Lying on Sides
3. ____ Lying on Stomach
4. ____ Turning Over in Bed
5. ____ Stooping
6. ____ Using Stairs/Ladder
7. ____ Gripping
8. ____ Pushing / Pulling
9. ____ Reaching
10. ____ Dressing Self
11. ____ Sexual Activity
12. ____ Getting In / Out of Car
13. ____ Sitting/Driving/Riding
14. ____ Using a Computer
15. ____ Kneeling
16. ____ Walking
17. ____ Standing
18. ____ Bending Forward
19. ____ Lifting
20. ____ Cough / Sneeze/ Grunt

YES NO

☐ ☐ Does the Discomfort Interfere with your Sleep?
- ♦How Many Times Does It Wake You Up? _____

☐ ☐ Do You Sleep with a Pillow? How Many? _____
- ♦Where? _____
- ♦What Positions Do You Sleep In? _____
- ♦How Old is Your Mattress? _____

☐ ☐ Does Using Heat Affect the Pain? How? _____
☐ ☐ Does Using Cold Affect the Pain? How? _____
☐ ☐ Do You Wear a Heel Lift? Which Side? (**Left** or **Right**)
☐ ☐ Do You Wear Foot Orthotics?
☐ ☐ Have you Had X-Rays of the Problem Area(s)?
- ♦When? _____
- ♦Facility? _____
- ♦Body Part(s)? _____

Females: Are You Pregnant? ☐Yes ☐No

Due Date: _____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

Males: Date of Last Prostate & Testicular Exam: _____

Neck & Headache Questions

YES NO

☐ ☐ Difficulty Turning Head? ☐ Left ☐Right
☐ ☐ Do You Hear Grating / Crackling Sounds?
☐ ☐ Was There a Feeling of Ripping or Tearing?
☐ ☐ Do You Try to "Crack" Your Own Neck?
☐ ☐ Do You Get Pain or Cracking in Jaw?
☐ ☐ Family History of Headaches?
☐ ☐ Do You have Nausea, Vomiting, Visual Disturbances, Altered Hearing, Ringing in Ears, or Loss of Balance?
☐ ☐ Do You Pain or Pressure Behind the Eye(s)? Rt or Lt
☐ ☐ Do You Have Abnormal Blood Pressure?

♦Frequency of Headaches: _____ per _____
♦Date of Last Eye Exam: _____. Any Rx Changes? Y or N

Low Back Pain Questions

YES NO

☐ ☐ Does Pain Radiate to the Abdomen and/or Groin?
☐ ☐ Any Impairment of Bowel or Bladder Function?
- ♦Explain? _____

☐ ☐ Was There a Feeling of Ripping or Tearing?
☐ ☐ Do You Try to "Crack" Your Own Back?

Past Medical History

☐ Never ☐ 1-3 Times ☐ 4 or More Times: How Many Times Have You Had the Condition That You Are Seeing Us for Today?

YES NO

☐ ☐ **Do You Suffer From Any Other Health Condition(s)?** (Check All That Apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer
☐ Arthritis ☐ Infertility Issues ☐ Others: _____

☐ ☐ **Have You Ever Seen a Chiropractor Before?**

♦ When Was the Last Time You Were Seen? _____ Which Dr.? _____

♦ For What Problem(s)? _____ Were You Helped? _____

♦ How Often Were You Being Seen? _____ Why Did You Leave? _____

♦ List Any Other Chiropractors You've Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

☐ ☐ **Have You Ever Seen a Medical Doctor for This Condition Before?** (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

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 the above Carrier 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.

I hereby authorize the doctors Cornerstone Chiropractic & Wellness to perform an examination, including x-rays if indicated, and to provide chiropractic services to me (or my dependants) based on the information provided herein.

_____ _____

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

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