CONFIDENTIAL PATIENT CASE HISTORY

PERSONAL INFORMATION:

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Preferred Phone Number (H,C,W) _____ Alt Phone (H,C,W)_____

Age _____ Date of Birth _____ Gender: F M # Children _____ Marital Status: M S W D P

Height _____ft _____in Weight _____lbs Lowest Adult Weight _____lbs Highest Adult Weight _____lbs

Employer _____ Occupation _____

Emergency Contact (Parent if Pt is a minor) _____ Phone_____

Email: _____How did you hear about us? _____

HEALTH INFORMATION:

Main reason for today's visit _____

Please list any other concerns (physical , emotional, mental) in order of importance _____

_____

When did this main condition start? _____ How did this condition begin? _____

Have you had this or similar conditions previously? _____

What percent of the day do you experience this condition? _____

Is this condition changing? Getting better _____ Getting Worse _____ Not Changing _____

How severe is this condition at its: a. worst: None 1 2 3 4 5 6 7 8 9 10 Unbearable

b. best: None 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes your condition feel worse? _____

What makes your condition feel better? _____

How does this condition affect your daily life? _____

What treatment have you received for this condition? _____

Have you been to a chiropractor before? Who? When? _____

Have you been to a massage therapist before? Who? When? _____

Name and location of family physician _____

List surgical operations/serious illnesses and years _____

_____

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: _____

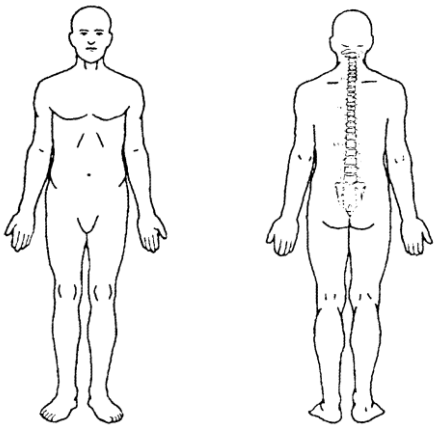
Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years

Describe: _____

Medications (prescription and over-the-counter), nutritional/herbal supplements you currently take _____

_____

Please mark your areas of pain on the figures below.



Past	Present	
____	____	Headaches
____	____	Neck Pain
____	____	Upper back pain
____	____	Mid Back Pain
____	____	Low Back Pain
____	____	Shoulder Pain
____	____	Elbow/Arm Pain
____	____	Wrist/Hand Pain
____	____	Hip/Upper Leg Pain
____	____	Knee/Lower Leg Pain
____	____	Jaw Pain
____	____	Joint Swelling/Stiffness/Arthritis
____	____	General Fatigue
____	____	Neurological Condition
____	____	Visual Disturbances
____	____	Dizziness

Past	Present		Past	Present	
____	____	Skin Issues	____	____	Abnormal Weight Gain/Loss
____	____	Eye/ear/nose/throat Problems	____	____	Allergies
____	____	Respiratory Condition	____	____	Autoimmune Disease
____	____	Heart Condition	____	____	Cancer
____	____	Chest Pain	____	____	Chronic Sinusitis
____	____	Blood Disorder	____	____	Depression
____	____	Abdominal Pain	____	____	Diabetes
____	____	Ulcer	____	____	Hepatitis
____	____	Liver/Gallbladder Problems	____	____	High Blood Pressure
____	____	Digestion Issues	____	____	HIV/AIDS
____	____	Bowel/Bladder Issues	____	____	Loss of Appetite
____	____	Menstrual Irregularity	____	____	Stroke
____	____	Prostate Problems	____	____	Tumor

Other _____

Please list if any immediate family members have/had any of the above _____

_____

Describe your diet _____

Do you exercise? Yes ____ No ____ If so, what type and how often _____

What do you do for recreation and relaxation? _____

What are your hobbies? _____

Rate your stress level Low 1 2 3 4 5 6 7 8 9 10 High

What factors contribute most to your stress level? _____

Rate your energy level Low 1 2 3 4 5 6 7 8 9 10 High

Rate the quality of your sleep Low 1 2 3 4 5 6 7 8 9 10 High Hours/night _____

What do you expect from your visit/treatment today? _____

How do you rate your overall health? Very Poor Poor Fair Good Excellent

How committed are you in taking responsibility for your healing and following through with your treatment?

Low 1 2 3 4 5 6 7 8 9 10 High

PAYMENT INFORMATION:
We will file your Medicare insurance claims for you. We do not participate with any other insurance companies, but we will make sure you have all the necessary documentation so that you may file for Out of Network benefits. Payment for your appointment is due on the day of service. We accept cash, checks, and credit/debit/HSA cards.

RELEASE OF MEDICAL INFORMATION:
I authorize the release of all health information in my record that is relevant to any insurance company or public agency which may be involved with my care for the purpose of determining benefits. I authorize St Croix Chiropractic and Wellness to review my medical history and insurance information for the purpose of providing chiropractic care. I understand that this authorization is in effect for the duration of my treatment and or until all outstanding sums relating to this treatment are satisfied or until I choose to revoke it in writing to: St. Croix Chiropractic and Wellness, P.O Box 883 St Croix Falls, WI 54024

INFORMATION ABOUT POSSIBLE RISKS OF TREATMENT:
You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is required by law, and is simply an effort to make you better informed so you may give or withhold your consent to the procedure. You have the right to refuse participation at any point, before or during the procedure.

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health procedure, complications may arise during treatment. These complications include bruising, soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or burns. These are extremely rare occurrences.

CONSENT FOR TREATMENT:
I authorize Dr. Joy K. Zasadny, DC, to perform an examination, diagnostic testing and treatment as deemed necessary. I certify that no guarantee or assurance has been made to the results that may be obtained. I certify that the information I have provided is correct to the best of my knowledge, and I will not hold Dr. Joy responsible for any errors or omissions that may have been made in the completion of this form. Having carefully read the above, I hereby give my informed consent to have chiropractic care administered.

I give permission to receive massage therapy/cupping from a licensed massage therapist. I understand the possible risks include muscle soreness, bruising, and minor burns. I understand that I may stop the session at any time.

I have been informed of the HIPAA patient privacy. _____ (initial here)

By signing below, I give consent to treatment and the use or disclosure of my personal health information as noted in the Notice of Privacy Practices.

_____

Signature of Patient or Responsible Party Date Relationship to Patient

Patient Name _____