Belleville Chiropractic and Wellness Center
PH: (608) 424 1840

1100 Bellwest Blvd
Belleville, WI 53508
Fax: (608) 424 1815

PATIENT HEALTH HISTORY AND INTRODUCTION

Today's Date ____________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name____________________________________ **Nick Name**____

Last Name ____________________________________ **Date of Birth** ______________________ **Age** ____________

Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other

Address 1 ____

City____ **State**_____________ **Zip Code** _______________________

Primary Phone _______________________________ **Is this a cell phone? [ ] Yes [ ] No**

Secondary Phone _____________________________ **Is this a cell phone? [ ] Yes [ ] No**

Email address: ____
By providing my email address, I authorize my doctor to contact me via the email address provided.

Emergency Contact person: Name ________________________________ **Phone #** ________________________

Email address: ____
By providing my email address, I authorize my doctor to contact me via the email address provided.

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_________	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

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Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: ______________________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including, Name of, Frequency taken and Dosage and How many are in your prescription (ie~30-60-90 etc.. If there are no current medications, Check here: ❑

1) ______________________ **5)** ______________________

2) ______________________ **6)** ______________________

3) ______________________ **7)** ______________________

4) ______________________ **8)** ______________________

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Present MD:______________________________

Last visit to a physician:____________**Reason:**______________________________

List any operations you may have had:______________________________

____

Briefly list your main health problems: ______________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describes: ______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

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If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure
If yes, other comments regarding Diabetes: ____

Do you have any health problems that are listed below, please circle all that apply to you:

1. Headaches 2. Sinus trouble 3. Anemia 4. Rheumatic Fever 5. Cancer 6. Arthritis

7. Allergies 8. Hernia 9. Diabetes 10. Heart Trouble 11. Backaches 12. Dizziness 13. Hyperactivity

14. Numbness in arms/hands 15. Foot/ankle/knee Pains 16. Arm/wrist Pains 17. Tingling in arms/legs

18. Neck/back Pains 19. Shoulder Pains 20. Sleeping problems 21. Stomach Problems

22. Diarrhea/Constipation 23. Weight gain/loss 24. Heart burn 25. Fatigue 26. Asthma

27. Other information or health complaints you would like us to be aware of__________________________

____

Previous Chiropractor:______________________________ **Date of last visit:**___________________________

Reason for leaving:____

Purpose of this appointment:____

____

How long have you suffered with this problem?____

When and how did it start:____

What is the pattern of this problem? Constant ______,Intermittent,______Occasional_____,Cyclic_______

What actives make this problem worse?____

____

What have tried to get rid of this problem that did not work? ____

____

What gives you some temporary relief?____

On a scale of 1 to10, with 10 being the highest, rate your commitment in helping us solve this problem:____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

For women only

Date of your last menstrual period:______________**Are you using any means of contraception?**__________

Do you experience severe cramping with your menstrual period?____________________________________

Do you suffer from PMS? ____

Signature of Patient ____**Date:**______________

Referred to our center by:____

To be performed by clinic staff:

Height: ______inches **Weight:** __________ pounds **BP:** _______ / ________