Reilly Chiropractic, 3032 Commercial Boulevard, Chippewa Falls, WI 54729

Phone (715)723-2892 Fax (715)723-3540

PATIENT INFORMATION

Name: ____ (Age) _______ Gender: M F Date: __________

Home Address: ____ Home Phone: ( ) ___________________________

City, State, Zip: ____ Work Phone: ( ) ___________________________

Email Address: ____ Cell Phone: ( ) ___________________________

Birth Date: ______ / ______ / _______ Social Security #: ________ - ______ - _________ Marital Status: S M D W

Names of Children: ____ Ages: ____________________

Occupation: ____ Employer Name: _________________________________

Spouse's Name: _________________________ Work Phone: ( )______________ Cell Phone: ( ) ______________________

Spouse's Employer: _______________________________________ Occupation: ____

How were you referred to this office? ____

CHIROPRACTIC EXPERIENCE

Have you seen a chiropractor before? ☐ Yes ☐ No Who? ________________________________ When? ___________________

Reason for visits: ____

How did you respond? ____

How frequently were you seen? ____

Did you receive maintenance or supportive care? ☐ Yes ☐ No ☐ Not Sure if yes @ what Frequency? ___________________________

Did your previous chiropractor take x-rays? ☐ Yes ☐ No ☐ Not Sure

Are you aware of any of your poor posture habits? ☐ Yes ☐ No ☐ Not Sure

Explain: ____

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No ☐ Not Sure

Explain: ____

GOALS FOR CARE

Indicate **one** of the following statements that apply to you:

☐ I have a specific health concern. (I want ***short term relief only*** without a corrective or maintenance program)

☐ I want to ensure that my health concerns do not become an ongoing problem. (I want ***relief and to maintain a pain free state*** of health)

☐ I am interested in learning how to improve my quality of life. (I want ***relief and am motivated to correct the problem*** and change my lifestyle to support and maintain a pain free state of health)

Are you healthier now than you were 1 year ago? ☐ Yes ☐ No
How/Why? ____

Is it your goal to be healthier 1 year from now than you are today? ☐ Yes ☐ No
Do you have a plan on improving your health? ____

____

Have you ever been advised on lifestyle choices for good health? ☐ Yes ☐ No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: ______________________

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Do you smoke? Yes No How much? ______________________

Do you drink alcohol? Yes No How much / week? ______________________

Do you drink coffee or caffeine? Yes No How many cups / day? Or what type? ______________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? ______________________

____

REVIEW OF SYSTEMS

CERVICAL SPINE (NECK):

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Recent weight loss
- ❑ Fever
- ❑ Chills
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):

- ❑ Heart Palpitations or Arrythmia
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Heart Attacks/Angina
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Pain On Deep Inspiration/Expiration
- ❑ Chest pain or pressure
- ❑ Shortness of breath
- ❑ Peripheral edema
- ❑ Blood clots
- ❑ Abnormal bleeding
- ❑ Bleeding
- ❑ Varicose Veins
- ❑ Cramping in thighs
- ❑ Nervousness, anxiety
- ❑ Depression
- ❑ Cancer

THOPRACIC SPINE (MID BACK):

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux or Heartburn
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/Irritable after eating or when you haven't eaten for a while
- ❑ Rashes
- ❑ Sores
- ❑ Blisters
- ❑ Growths
- ❑ Heat or cold intolerance
- ❑ Excessive thirst
- ❑ Diabetes

LUMBAR SPINE (LOW BACK):

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions not mentioned: ______________________

Please list any medications currently taking and their purpose: ______________________

Please list all past surgeries: ______________________

Please list all previous accidents and falls: ______________________

PRIMARY CONCERN FOR THIS VISIT

Reason for this visit – Main Concern: ____

Is this concern related to an auto accident / work injury? ☐ Yes ☐ No If so, when: ___________________________

When did this condition begin? __________/_____/________ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: ___________________________

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: ___________________________

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: ___________________________

Who have you seen for this? ___________________________ What did they do? ___________________________

How did you respond? ____

SECONDARY CONCERN FOR THIS VISIT

Reason for this visit – Main Concern: ____

Is this concern related to an auto accident / work injury? ☐ Yes ☐ No If so, when: ___________________________

When did this condition begin? __________/_____/________ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: ___________________________

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: ___________________________

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: ___________________________

Who have you seen for this? ___________________________ What did they do? ___________________________

How did you respond? ____

ADDITIONAL NOTES / COMMENTS: (onset, intensity, duration, frequency)

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Chronic Musculoskeletal Complaints:

- ☐ Low back pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Pain into hips/legs/feet
- ☐ Headaches
- ☐ Pain into shoulders/arms/hands