Reilly Chiropractic, 4751 W. Park Ave, 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:** ( ) ______________

CONSENT FOR USAGE OF EMAIL AND TEXT FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS ☐ **Yes** ☐ **No**

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

GOALS FOR CARE

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

☐ I ONLY want ***short term relief only*** without a corrective or maintenance program

☐ I want ***relief and to maintain a pain free state*** of health

HEALTHY 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 stretch? Yes No How often? 1X 2X 3X 4X 5X per week other: ______________

What stretches? Yoga Pilates Foam Roll Lacrosse/Massage Ball Other:______________

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)? ______________________________

____

Please list any medications currently taking and their purpose: ______________________________

____

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

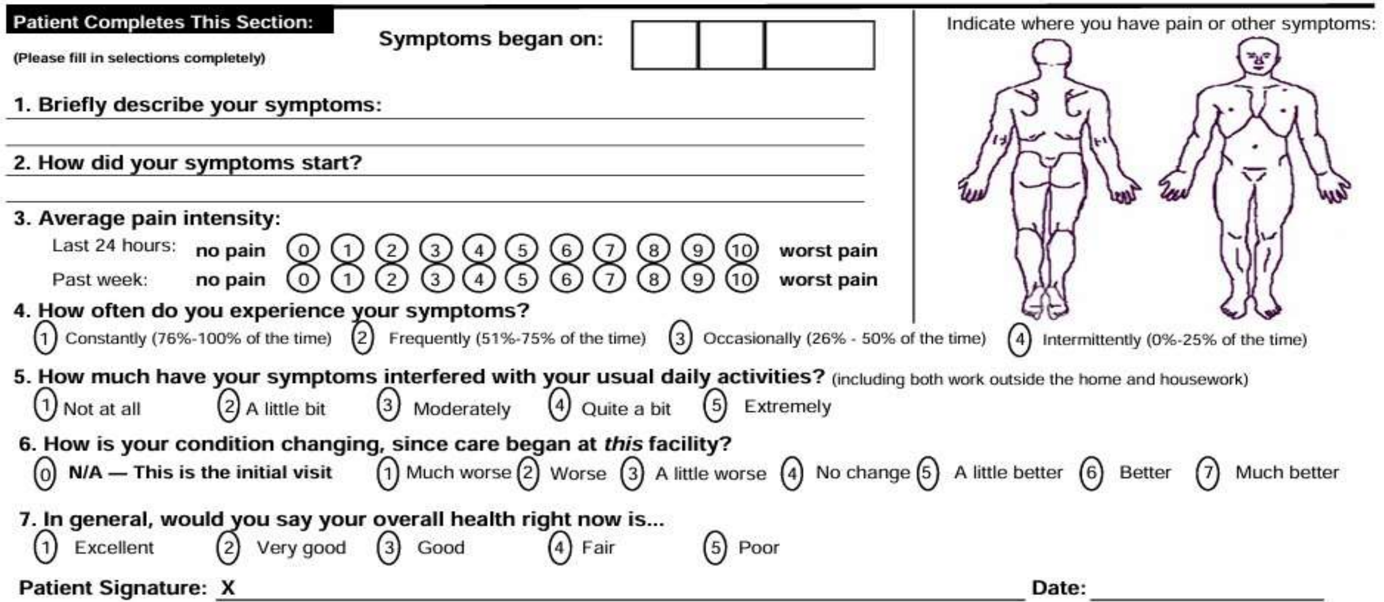
LUMBAR SPINE (LOW BACK):

- ❑ 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 all past surgeries: ________________________________

Please list all previous accidents and falls: ________________________________



Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on: [ ] [ ] [ ]

1. Briefly describe your symptoms: ________________________________

2. How did your symptoms start? ________________________________

3. Average pain intensity:

Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Indicate where you have pain or other symptoms:

Patient Signature: X ________________________________ **Date:** ____________