INNOVATIVE Health
Chiropractic • Laser Therapy
Functional Medicine
2114 Schofield Avenue • Weston, WI 54476

PATIENT HEALTH HISTORY

☐ New Patient
☐ Reactivate (1 yr)

Please fill out this form as completely as possible. In order for us to provide the very best care, it is important that we get a complete picture of your overall health. In addition, the U.S. Government requires that we collect certain data including your social security number, race/ethnicity, smoking status, and other demographic information as requested on this form.

Legal Name (*First, Middle, Last*):		Today's Date:
Street Address:		Home Phone: ☐ Preferred
City / State / Zip:		Work Phone: ☐ Preferred
Social Security #:	Birthdate:	Cell Phone: ☐ Preferred
Driver's license #:	Sex: ☐ Male ☐ Female	Cell Carrier: (for text reminders)
Ethnicity: ☐ Non-Hispanic ☐ Hispanic	Email:	

Race: ☐ White/Caucasian ☐ African American/Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____

Occupation:	Employer:
Primary Medical Doctor:	Medical Doctor Clinic & City:
Emergency Contact:	Emergency Contact's Phone:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name:
Spouse's Phone:	Spouse's Employer:

How Did You Hear About Us? (*Check all that apply*) ☐ I have been a past patient ☐ Referred by (name): _____
☐ Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Yellow Pages ☐ Sign/Location ☐ Other: _____

INSURANCE COVERAGE

Do you have Insurance? ☐ No ☐ Yes If yes, please provide card for us to photocopy.

	Primary Insurance Provider	Secondary Insurance Provider
Insurance Company:		
Phone Number:		
Policy / Subscriber ID Number:		
Group Number:		
Policyholder Name:	☐ Check if different address	☐ Check if different address
Policyholder Relationship to You:		
Policyholder Date of Birth:		
Policyholder Employer:		

SOCIAL HEALTH HISTORY

Recreational Activities / Hobbies:

Do You Exercise? ☐ No ☐ Yes If Yes, in what way? How often per week?

Do you consume Caffeine (Coffee, Tea, Soda, Energy Drinks)? ☐ No ☐ Yes If Yes, how much per day?

Do you consume Alcohol (Beer, Wine, Mixed Drinks)? ☐ No ☐ Yes If Yes, how much per week?

Smoking Status *(If 13 years old or older):* ☐ Never ☐ Former (___ Packs/day or ___ Cigarettes/day from Age ____ to Age _____)
☐ Smoker—Some days (NOT daily) ☐ Smoker—Daily (____ Packs/day or ____ Cigarettes/day for _____ Years)

PRESENTING ILLNESS / CHIEF COMPLAINT

What are your symptoms:

What caused the symptoms/injury?

Date symptoms began: | ☐ Work Related ☐ Auto Accident (Please provide copies of ALL Documents)

Have you seen a medical doctor for this condition? ☐ No ☐ Yes If Yes, Doctor's Name: Clinic:

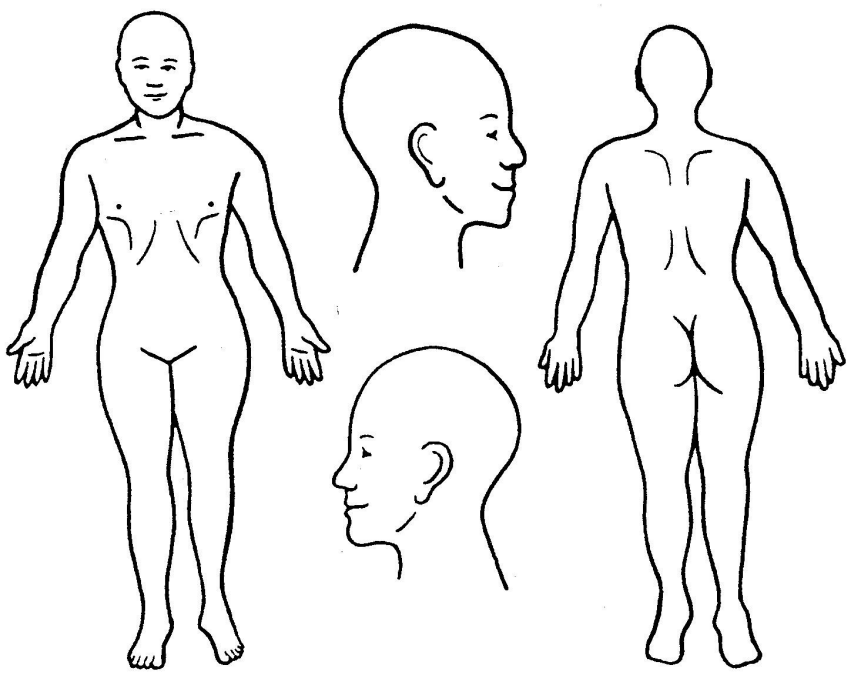
FEMALES: Are you pregnant? ☐ No ☐ Yes If Yes, Due Date: Doctor:

Show us your pain. Use the symbols from the top box on the left to indicate the location and type of pain you are having.

XXX	Burning
(((	Aching
000	Pins & Needles
- - -	Numbness
: : :	Sharp Pains

Pain is:	
____	Constant
____	Comes & Goes
____	Getting Better
____	Getting Worse
____	Staying Same

Better		Worse
____	Morning	_____
____	Midday	_____
____	Evening	_____



Rate your pain on the scale below. If there is more than one area of pain, please indicate the pain level (0 to 100) next to each area as appropriate.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

NO PAIN INTOLERABLE

Please mark any of the following activities which you find to be painful or difficult.

____ Lying on back	____ Dressing Self	____ Lifting	____ Kneeling	____ Twist/Turn Left/Right
____ Lying on side	____ Stooping	____ Gripping	____ Bending Forward	____ Sitting/Driving/Riding
____ Lying on stomach	____ Pushing/Pulling	____ Standing	____ Get In/Out of Car	____ Using Computer
____ Turning over in bed	____ Reaching	____ Walking	____ Sexual Activity	____ Going Up/Down Stairs

____ Cough / Sneeze / Grunt (If painful, where? _____)

Does the pain interfere with your sleep? _____ # of times you wake up:_____ Sleep position: _____ # of pillows: _____

MEDICAL HISTORY

Have you ever seen a chiropractor? ☐ No ☐ Yes If Yes, Doctor's Name: Clinic:

List major illnesses, injuries, falls, hospitalizations, accidents, or surgeries: ☐ None

Date	Condition(s)	Treating Doctor	Results
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

List current prescriptions, over-the-counter medications, and supplements: ☐ None

Name	Dosage *(mg, mL, …)*	Form *(Tablets, Caps…)*	How Often *(times per day, wk, mo)*	Duration *Chronic*	*As Needed*	*Unknown*
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			

List allergies ☐ None

Drugs, Medications (ADR):	Foods:
Environmental:	Other: (latex, animals...)

FAMILY MEDICAL HISTORY

List medical conditions experienced by yourself and immediate family members in the grid below.

	Self	**Mother**	**Father**	**Sister**	**Brother**
Example:		*Breast Cancer*	*Healthy*		*Died of Heart attack at 53*
Eyes (glasses/contacts, cataracts, glaucoma, blindness, etc.)					
Ear, Nose, Mouth, Throat (hearing loss, ear infections, sinus issues, allergies, etc.)					
Cardiovascular (heart attack, cholesterol, high BP, congestive heart failure, pacemaker, etc.)					
Respiratory (lungs, breathing, asthma, COPD, etc.)					
Neurological (nerve issues, weakness, numbness, etc.)					
Endocrine (thyroid, hormonal imbalances, liver, etc.)					
Gastrointestinal (acid reflux, ulcers, IBS, gall bladder, etc.)					
Genitourinary (male/female reproductive, kidney, bladder, etc.)					
Skin (rashes, skin cancer, dryness, psoriasis, eczema, hair, etc.)					
Psychiatric (anxiety, depression, bipolar, ADD, ADHD, etc.)					
Other (please describe)					

If you are currently receiving treatment for a medical condition, please describe:

Is there anything else you think we should know?

I certify that the above statements are true and complete to the best of my knowledge. I authorize the doctor to examine and treat my condition through the use of chiropractic care, and I give authority for these procedures to be performed.

Patient Signature: _____ Date: _____

Parent/Guardian/Legal Representative:_____ Date: _____

Staff Initials:

INFORMED CONSENT

While chiropractic care is remarkably safe, like any health care treatment, it does have some risks. It is your right as a patient to be informed of the potential risks of care so that you are fully informed in consenting to treatment.

The nature of the chiropractic adjustment - The primary treatment used by Doctors of Chiropractic is called spinal manipulative therapy. Your doctor may use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment - As a part of the analysis, examination, and treatment, a variety of tests and therapies may be used in your care including: spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies (x-rays), palpation, orthopedic testing, postural analysis, basic neurological testing, hot/cold therapy, vital signs, EMS, ultrasound, spinal decompression therapy, and/or high intensity laser therapy.

The material risks inherent in chiropractic adjustment - As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

The probability of those risks occurring - Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor will check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. *Statistically speaking, the risk of stroke from unknown causes in the general population actually exceeds the risk of stroke following a chiropractic adjustment*. The other complications are also generally described as rare.

Results - As with any health care option, we cannot guarantee any particular results from our chiropractic treatment. If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another qualified health care provider.

The availability and nature of other treatment options - Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers; hospitalization; surgery. There are risks and benefits with each of these options, and you may wish to discuss these risks and benefits with your primary medical physician.

The risks and dangers attendant to remaining untreated - Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

PREGNANCY RELEASE – This is to certify that, to the best of my knowledge, I am not pregnant. I give my permission to perform x-ray evaluation with the understanding that x-ray can be hazardous to an unborn child. _____

(Patient Initials)

Having carefully read the above, I hereby give my informed consent to have the doctors of Innovative Health administer chiropractic care.

Patient Name (printed)	Date
X	X
Patient Signature	Parent/Guardian/Legal Representative Signature