WILDBERG
CHIROPRACTIC
OFFICE, S.C.

PATIENT QUESTIONNAIRE

(PLEASE PRINT)

New Patient ☐
Reactivate ☐
Other ☐

***Full Legal Name** _____ ***Birth Date** _____

***Address** _____
Street / PO Box *City* *State* *Zip*

Home Phone** _____Mobile Phone** _____ **Email** _____

Would you like to receive Email or Text reminders for appointments? ☐ No ☐ Yes ***(If yes, provide carrier:_____)***

***Employer** _____ ***Work Phone** _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse Name _____ Phone # _____Spouse Employer _____

Legal Guardian (if applicable):_____

***Did anyone refer you to our office**? ☐ No ☐ Yes – Who _____

HISTORY OF PRESENTING ILLNESS/INJURY

***What are your symptoms?** _____

***Date your symptoms began?** _____

***How did it occur?** _____

☐ ***Work Related** ☐ ***Auto Accident** ***(*Provide copies of ALL Documents)*** Have you missed any work? ☐ No ☐ Yes

How Much? _____hours / days / weeks / months

***Do you have any recent X-rays of that area(s)?** ☐ No ☐ Yes – Facility where taken/Date? _____

WHAT IMPROVES THIS CONDITION? CHECK ALL THAT APPLY

☐ Nothing ☐ Chiropractic Adjustments ☐ Cold packs ☐ Exercise
☐ Heat packs ☐ Massage ☐ Medications ☐ Physical Therapy
☐ Rest ☐ Stretching

WHAT AGGRAVATES THIS CONDITION? CHECK ALL THAT APPLY

☐ Almost any movement ☐ Athletic activity/exercise ☐ Bathing ☐Bending
☐ Caring for family ☐ Carrying ☐ Climbing stairs ☐ Computer use
☐ Cooking ☐ Coughing/sneezing ☐ Driving ☐ Eating
☐ Getting in/out of car ☐ Getting out of bed ☐ Getting up from sitting
☐ Lifting ☐ Looking over shoulder ☐ Sexual Activity ☐ Lying down
☐ Pulling ☐ Pushing ☐ Reaching ☐ Reading
☐ Running ☐ Sitting ☐ Standing ☐ Stress
☐ Twisting/turning ☐ Walking ☐ Working ☐ Yard work

HISTORY OF PRESENT ILLNESS - CHIEF COMPLAINT(S)

Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate symbols from the left. Rate your pain on the scale below from 0 to 10 (0 = no pain; 10 = unbearable pain). If there is more than one area of discomfort, please rate the pain 0 to 100 next to each area as appropriate.

NO PAIN ***PAIN SCALE (grade pain today***

Current complaint (grade pain today):

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Unbearable**

X X X Burning Pain
(((Aching Pain
0 0 0 Pins & Needles
- - - Numbness
: : : Sharp Pain

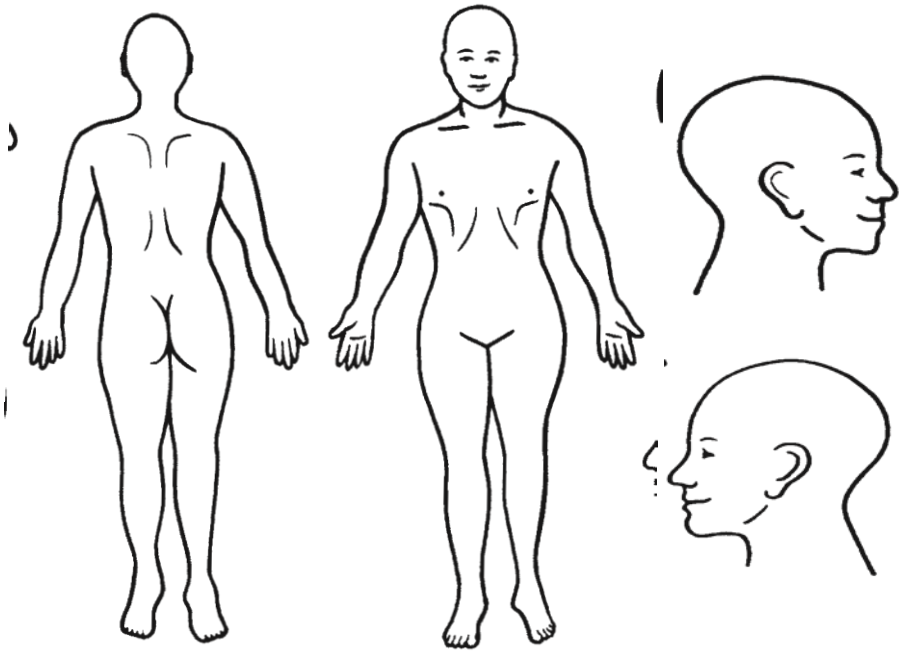
__ Constant
__ Comes/Goes

_____

__ Getting Better
__ Getting Worse
__ Staying Same

_____

Better: Worse:
___ AM ___
___ MID-DAY ___
___ PM ___



Please check the activities of daily living that have been affected by current condition:
Indicate your ability to perform the following Activities of Daily Living. Please check appropriate box:

	Unable	***Limited***	***Painful***	***Difficult***	***Normal***	***Haven't Tried***
Lying on Back	☐	☐	☐	☐	☐	☐
Dressing Self	☐	☐	☐	☐	☐	☐
Lifting	☐	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐	☐
Gripping	☐	☐	☐	☐	☐	☐
Twist/Turn – LEFT / RIGHT	☐	☐	☐	☐	☐	☐
Bending Forward	☐	☐	☐	☐	☐	☐
Using Stairs	☐	☐	☐	☐	☐	☐
Sexual Activity	☐	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐
Sitting/Driving/Riding	☐	☐	☐	☐	☐	☐
Pushing/Pulling/Reaching	☐	☐	☐	☐	☐	☐
Turning Over in Bed	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐
Get In/Out of Car	☐	☐	☐	☐	☐	☐

___ Cough/Sneeze/Grunt – (if painful, where _____)

___ Sleeping - (# times wake up _____ ; # pillows _____; position sleep in: _____

PATIENT DEMOGRAHICS

SSN# __________-__________-__________

***Gender** ☐ Male ☐ Female

***Ethnicity (select one)** ☐ **Hispanic** ☐ **Not Hispanic**

Race (select one)

☐ **Alaska Native** ☐ **Asian** ☐ **Native Hawaiian** ☐ **White/Caucasian** ☐ **American Indian** ☐ **Black/African American**

☐ **Pacific Islander** ☐ **Other:**_________________________________

***Language (select one)**

☐ **English** ☐ **Spanish** ☐ **Other:**__________________

***How do you prefer to receive follow-up reminders for Preventive Care? (Select one)**

☐ **Letter** ☐ **Phone Call** ☐ **Email** ☐ **Fax**

***Allergies** ☐ **None –OR-** ☐ **See List Below**

Drug/Medication:	***Food:***	***Other Allergies (e.g.-animals, pollen, latex, etc)***
_______________	_______________	_______________
_______________	_______________	_______________
_______________	_______________	_______________
_______________	_______________	_______________

***Smoking Status (Individuals age 13 years and older):**

☐ Smoker-Daily (___Packs/day or ___Cigarettes/day – for: ___Years or Since: ______/_____/_____)
☐ Smoker-Some Days (NOT Daily)
☐ Former (___Packs/day or ___Cigarettes/day – from: Age ____ to Age ____)
☐ Never
☐ Smoker-Current Status Unknown

***Current Prescription Medications** ☐ None **– OR –** ☐ See List Below

Name of Prescription:	*Dose (mg, mL, etc)*	*Form (Tab, Caps, etc)*	*Duration (# times per day, wk, mo)* **- AND-**	*Chronic*	*As Needed*	*Unknown*
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____
_______________	_________	_________	____x per__________	_____	_____	_____

PAST MEDICAL HISTORY

FEMALES: Are You Pregnant? No☐ ☐Yes – Due Date:_____ Doctor: _____

Date of Last Gynecological & Breast Exam: _____

MALES: Date of Last Prostate & Testicular Exam: _____

How often have you had this condition that you are seeing us today for? ☐Never ☐1-3 Times ☐4 or More Times

Have you received care from a Chiropractor before? ☐No ☐Yes – Doctor/Clinic _____

Have you seen a medical doctor for this condition? ☐No ☐Yes – Doctor/Clinic_____

HEALTH CONDITIONS. CHECK ALL THAT APPLY

☐ Vision loss ☐ Cataracts ☐ Glaucoma ☐ Hearing loss ☐ Sinus issues ☐ Heart
☐ High BP ☐ High cholesterol ☐ Asthma ☐ COPD ☐ Weakness ☐ Numbness
☐ Thyroid ☐ Hormonal ☐ Liver ☐ Acid Reflux ☐ Ulcers ☐ Gall Bladder
☐ IBS ☐ Reproductive ☐ Kidney ☐ Bladder ☐ Osteoporosis ☐ Arthritis
☐ Psoriasis ☐ Eczema ☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADHD/ADD
☐ Diabetes ☐ Pregnancy ☐ Cancer:_____

LIST ANY PAST HISTORY OF ACCIDENTS OR TRAUMA. CHOOSE ALL THAT APPLY.

☐ No previous trauma ☐ Automobile accident ☐ Slip and fall ☐ Motorcycle accident
☐ Boating accident ☐ Permanent disability ☐ Major hospitalization
☐ Broken bones ☐ Major sprain/strains ☐ Surgery (minor or major)

Describe details of checked boxes:

_____

_____

FAMILY HEALTH HISTORY. CHOOSE ALL THAT APPLY TO BLOOD RELATIVES ONLY.

MOTHER: ☐ Alive - ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ High BP ☐ High cholesterol
☐ Deceased from:_____

FATHER: ☐ Alive - ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ High BP ☐ High cholesterol
☐ Deceased from:_____

CHILDREN: Number of children: _____
☐ Alive - ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ High BP ☐ High cholesterol
☐ Deceased from:_____

BROTHER(S): Number of brothers:_____
☐ Alive - ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ High BP ☐ High cholesterol
☐ Deceased from:_____

SISTER(S): Number of sister:_____
☐ Alive - ☐ Heart disease ☐ Cancer ☐ Diabetes ☐ High BP ☐ High cholesterol

☐ Deceased from:_____

SOCIAL HISTORY. CHECK ALL THAT APPLY.

Smoking status:	☐ Daily	☐ Some days	☐ Ex-smoker	☐ Non smoker	
Alcohol:	☐ Light drinker	☐ Moderate drinker	☐ Heavy drinker	☐ Non drinker	
Caffeine:	☐ 1-2 cups daily	☐ 2-5 cups daily	☐ 5 or more cups daily	☐ No caffeine	
Exercise:	☐ None	☐ Daily	☐ Every other day	☐ Once a week	☐ Very seldom
Diet:	☐ Restricted	☐ Unrestricted			
Work:	☐ Part-time	☐ Full-time	☐ Retired	☐ Homemaker	☐ Student
Work duties:	☐ Mostly sitting	☐ Mostly standing	☐ Mostly walking	☐ Mostly lifting	
	☐ Light duty	☐ Moderate duty	☐ Heavy duty		
	☐ Relaxed	☐ Enjoyable	☐ Stressful	☐ Difficult	

I CERTIFY THAT I'M THE PATIENT OR LEGAL GUARDIAN LISTED ABOVE. I HAVE READ/UNDERSTAND THE INCLUDED INFORMATION AND CERTIFY IT TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE COLLECTION AND USE OF THE ABOVE INFORMATION TO THIS OFFICE OF CHIROPRACTIC. I AUTHORIZE THIS OFFICE AND ITS STAFF TO EXAMINE AND TREAT MY CONDITION AS THE DOCTORS SEE FIT. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO ANY INSURANCE COMPANY, ATTORNEY OR ADJUSTER FOR THE PURPOSE OF CLAIM REIMBURSEMENT OF CHARGES INCURRED BY ME. I GRANT THE USE OF MY SIGNED STATEMENT OF AUTHORIZATION FOR REQUIRED INSURANCE SUBMISSIONS. I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME WILL BE CHARGED TO ME, AND I'M RESPONSIBLE FOR TIMELY PAYMENT OF SUCH SERVICES. I UNDERSTAND AND AGREE THAT HEALTH/ACCIDENT INSURANCE POLICIES ARE ARRANGEMENTS BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT FEES FOR PROFESSIONAL SERVICES WILL BECOME IMMEDIATELY DUE UPON SUSPENSION OR TERMINATION OF MY CARE OR TREATMENT.

SIGNATURE_____ DATE _____

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