



Dr. Kami Hansen
Dr. Caroline Ruppert
2850 County Road BB
Cottage Grove, WI 53527
Ph: 608-839-3513 Fax: 608-839-3533

Confidential Patient Information

Name, Address, Age, Date of Birth, Sex, City, State, Zip, Home Phone, Cell Phone, Work Phone, Primary Contact Number, E-mail, Marital Status, # Children, Spouse's Name, SSN, Occupation, Employer, Race, Ethnicity, Hispanic/Non-Hispanic, Emergency contact/phone number, Your health insurance company, Insured's Name, Insured's Date of Birth, Family Physician, Facility

Whom may we thank for referring you to us/how did you hear about our clinic?

Are you currently enrolled in college? Yes No Part time Full time

Do you have a current military ID? Yes No

Main Complaint?

How do you want us to handle your problem? Temporary relief (Help the symptom) Maximum correction (Correct the cause for maximum stability in the future)

Are your present problems due to an injury? Yes No On the Job Auto Accident Other

If this is due to an accident, has the accident been reported? Yes No Employer Auto Insurance Carrier Other

If yes, please also fill out Workers Comp or Personal Injury Form

Is this injury case still open? Yes No Unsure Have you retained an attorney? Yes No

Women Only:

To the best of my knowledge: I am pregnant I am NOT pregnant and give my permission do NOT give my permission to x-ray me for diagnostic interpretation

MEDICATIONS

List all Drugs you are taking (include prescription and over the counter medications). Use back of sheet if necessary.

Table with 2 columns: Type, Purpose

Name: _____

PAST HISTORY

List all Surgeries, Falls, Auto Accidents, and Injuries (even those you thought were no big deal) and year if known:

Past Chiropractic Care: Yes No Who? _____ Last adjustment? _____ Good Results? Y N

Past Physical Therapy: Yes No For? _____ When? _____ Good Results? Y N

ACTIVITIES OF DAILY LIVING (ADL's)

1. Type of mattress (describe) _____ How old? _____

2. Sleeping position? Side Stomach Back Combination

3. Type of pillow? Foam Feather Other _____ How many? _____ How old? _____

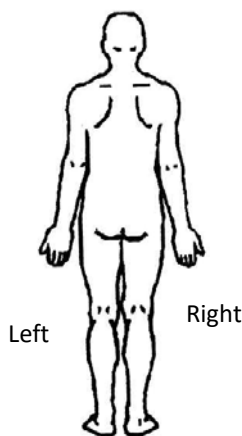
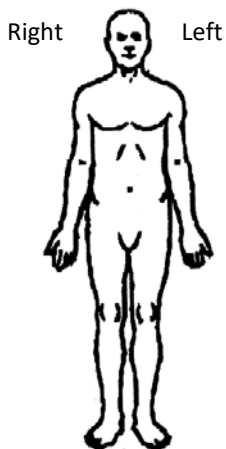
4. Do you sit on your wallet? Yes No

5. Define your stress level (use 1-10 scale, 10 being the most stressful). _____ work _____ home

6. Do you have current pain with any of the following (mark all that apply):

- | | | | | | |
|---------------------------------------|-----------------------------------|----------------------------------|---------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Stairs | <input type="checkbox"/> Lifting | <input type="checkbox"/> Doing Dishes | <input type="checkbox"/> Standing | <input type="checkbox"/> Getting Out Of Bed |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Riding | <input type="checkbox"/> Working | <input type="checkbox"/> Bending | <input type="checkbox"/> Reaching | <input type="checkbox"/> Energy Increases |
| <input type="checkbox"/> Sit to Stand | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Driving | <input type="checkbox"/> Exercising | <input type="checkbox"/> Sitting | <input type="checkbox"/> Getting On/Off Toilet |
| <input type="checkbox"/> Housework | | | | | <input type="checkbox"/> Yard work |

Please circle area and type of pain on the drawings below using the codes listed below



- | | |
|-----------------|--------------|
| N- Numbness | TH-Throbbing |
| P – Pain | SW-Swelling |
| SB-Stabbing | D – Dull |
| SH – Sharp | SO-Shooting |
| T – Tingling | B-Burning |
| A – Ache | C-Cramps |
| ST – Stiffness | S – Soreness |
| MS-Muscle Spasm | O-Other |

Name: _____

PERSONAL HISTORY

Mark "C" for current and "P" for past. Please mark "C" or "P" on all categories below that apply.

GENERAL SYSTEMS

- Cancer
- Diabetes
- Dizziness
- Epilepsy
- Fatigue(General/Muscular)
- Headache
- Hernia
- Loss of Sleep/Insomnia
- Migraines

GASTRO-INTESTINAL

- Belching or Gas
- Constipation
- Diarrhea
- Excessive Hunger/Thirst
- Heartburn/Acid Reflux
- Ulcers

SKIN

- Bruise Easily
- Eczema/Psoriasis
- Hives

SPINE/BACK

- Ankle/Foot R / L
- Broken Bones
- Difficulty while
(please circle)
standing walking sitting
bending lifting twisting
- Elbow R / L
- Herniated Discs
- Hip R / L
- Jaw Pain (TMJ) R / L
- Knee R / L
- Lower Back Pain R / L
- Mid Back Pain R / L
- Numbness, Tingling or
Pain in Buttocks, Legs,
Thighs, Feet, Toes R / L
- Numbness, Tingling or
Pain in Arms, Hands,
or Fingers R / L
- Neck Pain/Stiffness R/L
- Shoulder R / L
- Wrist/Hand R / L

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Impotence
- Inability to Control Urine

WOMEN ONLY

- Breast Implants
- Hot Flashes
- Irregular Cycle
- Painful Periods
- Pregnant
Due ____/____/____
- Taking Birth Control
- Last Menstrual Cycle
____/____/____

CARDIO-VASCULAR

- Chest Pain
- Heart Attack
- High/Low Blood Pressure
- Light Headed(Positional)
- Pacemaker
- Shortness of Breath
- Strokes
- High Cholesterol

RESPIRATORY

- Allergy
- Asthma/Wheezing
- Chronic Cough
- Sleep Apnea

EYE/EAR/NOSE/THROAT

- Ear Ache/Infections
- Ear Ringing
- Frequent Colds/Flu
- Sinusitis/Hayfever
- Sore Throats
- Tonsillitis

MISCELLANEOUS

- Loss of Bowel/Bladder
Function
- Night Pain
- Numbing/Tingling in
BOTH Arms and/or Legs
- Pain Wakes You From
Sleep
- Recent Infections/Night
Sweats
- Unexplained Weight Loss
- Vertigo
- Motion Sickness

Height_____	Weight_____
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FAMILY HISTORY

	Diabetes	Heart Disease	Cancer	Hypertension	Kidney Problems	Stroke
Mother (Age_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father (Age_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother (# of _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister (# of _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

- Smoking: Packs/Day_____ Never Smoked Past Smoker Coffee: Cups/Day_____
- Soda: Cans/Day_____ Alcohol: Drinks/Day_____ Exercise type_____
- Nutritional Supplements Taken_____

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1. _____

Location of pain: _____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____
Worse with (circle): sitting standing walking bending twisting lifting movement other _____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other _____ Did it help? Y N

Problem #2. _____

Location of pain: _____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____
Worse with (circle): sitting standing walking bending twisting lifting movement other _____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other _____ Did it help? Y N

Problem #3. _____

Location of pain: _____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____
Worse with (circle): sitting standing walking bending twisting lifting movement other _____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other _____ Did it help? Y N

#4. Additional Complaints (use back of sheet if needed)

Terms of Acceptance

The goal of our office is to enable patient to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it know, or to learn through healthcare procedures whatever he/she is suffering from a latent pathological defect, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a chiropractor at Heartland Family chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment, will be explained to me upon my request. It is understood and agreed that the amount paid to the doctor for x-ray's is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependents behalf in full or according to insured contractual agreement. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes No

MISSED APPOINTMENTS

There is a possible \$20 fee charged for all appointments that are not cancelled prior to scheduled visit.

I, _____, have read and fully understand the above statements. I hereby attest that the information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible.

Print Name: _____

Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

Parent Signature: _____ Date: _____