Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards.

Brandenburg Chiropractic
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Today's Date (MM/DD/YY) _____

Patient Number (office use only) _____

Whom may we thank for referring you? _____

Have you consulted a chiropractor before? O No O Yes **When?**_____ **Whom?**_____

Your Last Name _____ **Your Social Security #** _____ **Birth Date** _____ **Age** _____

Your First Name _____ **Your Middle Name** _____ **Gender:** O Male O Female

What name would you like for us to call you? _____

Address _____ **Marital Status**: O Married O Single

City _____ **State** _____ **Zip** _____ **Spouse's Name (if applicable)** _____

Cell Phone _____ **Email Address** _____

Emergency Contact _____ **Emergency Contact's Phone** _____

Your Occupation _____ **Your Employer** _____

Primary Care Provider's Name _____ **Insurance Carrier** _____

1. The symptom(s) that have prompted me to seek care today include:

_____

_____

_

2. And are the result of (darken one): O An accident or Injury
O Work O Auto O Other_____
O A worsening long-term problem
O Other

_____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)
0 O-O-O-O-O-O-O-O-O-O **10**
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
O Constant O Comes and goes.
How often? _____
_____

6. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____
_____

7. Quality and symptoms (What does it feel like?)
O Numbness
O Tingling
O Stiffness
O Dull
O Aching
O Cramps
O Nagging
O Sharp
O Burning
O Shooting
O Throbbing
O Stabbing
O Other _____
_____

8. Location (Where does it hurt?) **Circle the area(s) on the illustration**.

9. Prior Interventions (What have you done to relieve the symptoms?)
O Prescription Medications
O Over-the-counter Drugs
O Homeopathic Remedies
O Physical Therapy
O Surgery
O Acupuncture
O Chiropractic
O Massage
O Ice
O Heat
O Other_____

10. Aggravation or relieving factors (What makes it better or worse, such as time of day movements, certain activities, etc.)

What tends to worsen the problem?
_____

What tends to lessen the problem?
_____

11. What else should Dr. Hans Cesarz know about your current condition? _____
_____

_

_____

_

12. How does your current condition interfere with your:

Work or Career:

_____
Patient Name

_____
Patient Number

Consultation Notes:

_____
Doctor Initials

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **HAD** or currently **HAVE**.

Musculoskeletal

Had	Have		Had	Have		Had	Have	
O	O	Osteoporosis	O	O	Scoliosis	O	O	Back problems
O	O	Knee Injury	O	O	Shoulder problems	O	O	TMJ issues
O	O	Arthritis	O	O	Neck pain	O	O	Hip disorders
O	O	Foot/Ankle pain	O	O	Elbow/wrist pain	O	O	Poor posture

Neurological

Had	Have		Had	Have		Had	Have	
O	O	Depression	O	O	Headaches	O	O	Low Energy
O	O	Numbness						

Cardiovascular

Had	Have		Had	Have		Had	Have	
O	O	High blood pressure	O	O	Low blood pressure	O	O	High cholesterol
O	O	Poor circulation	O	O	Angina	O	O	Excessive bruising

Respiratory

Had	Have		Had	Have		Had	Have	
O	O	Asthma	O	O	Emphysema	O	O	Hay fever
O	O	Shortness of Breath	O	O	Pneumonia			

Digestive

Had	Have		Had	Have		Had	Have	
O	O	Heartburn	O	O	Constipation	O	O	Diarrhea

Senory

Had	Have		Had	Have		Had	Have	
O	O	Blurred vision	O	O	Ringing in ears	O	O	Hearing loss
O	O	Loss of smell	O	O	Loss of taste			

Past Personal and Family History

Please identify you past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Personal:

14. Illnesses

Check the illnesses you have **HAD** in the past or **HAVE** now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Malaria
O	O	Alcoholism	O	O	Measles
O	O	Allergies	O	O	Multiple Sclerosis
O	O	Arteriosclerosis	O	O	Mumps
O	O	Cancer	O	O	Polio
O	O	Chicken pox	O	O	Rheumatic Fever
O	O	Diabetes	O	O	Scarlet Fever
O	O	Epilepsy	O	O	Stroke
O	O	Glaucoma	O	O	Tuberculosis
O	O	Goiter	O	O	Typhoid Fever
O	O	Gout	O	O	Ulcer
O	O	Heart Disease	O	O	Other_____
O	O	Hepatitis			_____
O	O	HIV positive			

_____
Patient Name

_____
Patient Number

Consultation Notes:

_____
Doctor Initials

15. Operations

Surgical interventions, which may or may not have included hospitalization. the **CURRENTLY.**

O Appendix removal
O Bypass surgery
O Cancer
O Cosmetic surgery _____
O Elective surgery_____
_____
O Eye surgery
O Hysterectomy
O Pacemaker
O Spine _____
Replacement
_____
O Tonsillectomy
O Vasectomy
O Other: _____
Supplements
_____
_____
O None
_____

_____

17. Injuries

_____

Have you ever…

O Had a fractured or broken bone
O Had a spine or nerve disorder
_____
O Been knocked unconscious
_____
O Been injured in an accident
_____

_____

_____

16. Treatments

Check the ones you've received in **PAST** or are receiving

	Past	**Currently**
O Acupuncture	O	O
O Antibiotics	O	O
O Blood Transfusions	O	O
O Chemotherapy	O	O
O Chiropractic Care	O	O
O Dialysis	O	O
O Herbs	O	O
O Homeopathy	O	O
O Hormone	O	O
O Inhaler	O	O
O Massage Therapy	O	O
O Physical Therapy	O	O
O Nutritional	O	O

List:

Please list any Medications that you are currently taking._____

18. Family History

Some health issues are hereditary. Tell Dr. Hans Cesarz about the health of your immediate family members.

Relative	**Age(if living)**	**State of Health**		**Illness**	**Age of Death**	**Cause of Death**
		Good	**Poor**			**Natrual Illness**
Mother	_____	O	O	_____	_____	O O
Father	_____	O	O	_____	_____	O O
Sister 1	_____	O	O	_____	_____	O O
Sister 2	_____	O	O	_____	_____	O

_____
Patient Name

_____
Patient Number

Consultation Notes

_____
Doctor's Initials