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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270-422-4445
www.brandenburgchiropractic.com

____
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? ______________________

____

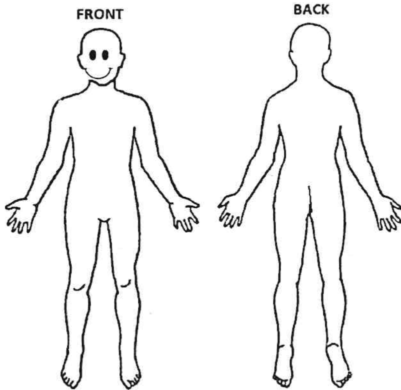
6. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

____

____

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: ______________________
Recreational activities:______________________
Household responsibilities:______________________

____
Patient Name

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		

Patient Name ____________

Consultation Notes:

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		

Doctor Initials ____________

15. Operations
Surgical interventions, which may or may not have included hospitalization.

O Appendix removal
O Bypass surgery
O Cancer
O Cosmetic surgery __________
O Elective surgery____________
____
O Eye surgery
O Hysterectomy
O Pacemaker
O Spine ____________________
____
O Tonsillectomy
O Vasectomy
O Other: ___________________
____
O None

16. Treatments
Check the ones you've received in the **PAST** or are receiving **CURRENTLY.**

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

List: _______________
____
____
____

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

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 Good	State of Health Poor	Illness	Age of Death	Cause of Death Natrual	Cause of Death Illness
Mother	______	O	O	____________________	______	O	O
Father	______	O	O	____________________	______	O	O
Sister 1	______	O	O	____________________	______	O	O
Sister 2	______	O	O	____________________	______	O	O
Brother 1	______	O	O	____________________	______	O	O
Brother 2	______	O	O	____________________	______	O	O

19. Are there any other hereditary health issues that you know about? If so, please list them here:____.

20. How much sleep do you average per night?_____**Hours**

21. What is the type and approximate age of your mattress and pillow? ____________
____

22. What is your preferred sleeping position?______________________________

____
Patient Name

Consultation Notes

____
Doctor's Initials

23. Activities of Daily Living

How does this condition interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Rising out of chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O
Lying Down	O	O	O	O
Bending Over	O	O	O	O
Climbing stairs	O	O	O	O
Using a computer	O	O	O	O
Getting in/out car	O	O	O	O
Driving a car	O	O	O	O
Looking over shoulder	O	O	O	O
Caring for family	O	O	O	O

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	O	O	O	O
Household Chores	O	O	O	O
Lifting Objects	O	O	O	O
Reaching overhead	O	O	O	O
Showering/Bathing	O	O	O	O
Dressing Myself	O	O	O	O
Getting to sleep	O	O	O	O
Staying asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O
Yard work	O	O	O	O

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial you agreement.

Initials____ **I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials____ **(Male and Female) I give consent for any medical X-rays needed to diagnose my condition. I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YY):________________**

Initials____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials____ **I acknowledge that any insurance I may have is a agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: ______________________________

______________________________ Signature

______________________________ Date (MM/DD/YY)

____
Patient Name

Consultation Notes

____
Doctor's Initials