

Waterford Chiropractic Office * New Patient Information Worksheet

Name: _____ **SS#:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Birth Date:** _____

Employed By: _____ **Spouse Name:** _____

Spouse's Birth Date: _____ **Spouse's SS#:** _____

Your E-mail Address: _____

Referred By: (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Other) _____

Which one of our patient's should we thank for referring you? _____

Please circle your current chief complaint(s) and/or symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain)

(Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other) _____

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past five years: : _____

Have you ever had spinal surgery? (No) (Yes) _____

List any serious condition the doctor should be aware of: _____

Previous Chiropractor: _____ **Were you satisfied?** (No) (Yes)

***Females: Are you pregnant at this time?** (No) (Yes) **Due Date:** _____

Office Policies: *If I am accepted as a patient at the Waterford Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent To Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Nielsen to proceed with any necessary treatment. I have read Dr. Nielsen's office policies and consent to treat information, and I agree with them by signing below:*

Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____

Waterford Chiropractic Office

Dr. G.E. Nielsen * e-mail: docnielsen@aol.com

Fax: (262) 534-2363 * Ph: (262) 534-3767

505 Aber Drive, P.O. Box 86

Waterford, WI 53185-0086

Patient Health History Worksheet

Patient's Name: _____ Date: _____

Significant Past Health History

Have you ever been hospitalized?

- a) No
- b) Yes: (Year: _____) (Reason: _____)

Have you had any surgeries?

- a) No
- b) Yes: (Year: _____) (Reason: _____)

Do you have any significant health problems?

- a) No
- b) Yes: (_____)

Significant Past Medical History

Have you seen another doctor for this condition?

- a) No
- b) Yes: (Name: _____)

Did this doctor recommend any treatment?

- a) No
- b) Yes: (_____)

Are you taking any medications?

- a) No
- b) Yes: (_____)

Significant Past Social History

Do you play any sports or exercise?

- a) No
- b) Yes: (_____)

How many hours do you sleep a night?

(_____)

How many hours a week do you work? (_____)

Significant Family Medical History

Did your father have any health problems?

- a) No
- b) Yes: (_____)

Did your mother have any health problems?

- a) No
- b) Yes: (_____)

Did your brother(s) have any health problems?

- a) No
- b) Yes: (_____)

Did your sister(s) have any health problems?

- a) No
- b) Yes: (_____)

Did your grandpa have any health problems?

- a) No
- b) Yes: (_____)

Did your grandma have any health problems?

- a) No
- b) Yes: (_____)

Health Risk Factors

Do you drink alcohol?

- a) No
- b) Yes: (_____)

Do you smoke?

- a) No
- b) Yes: (_____)

Anything else the doctor should know about?

- a) No
- b) Yes: (_____)

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Patient Health History Worksheet

Patient's Name: _____ Date: _____

Present Health History

When did your present condition begin?

- a) Gradual Onset (no specific date)
- b) Date: _____

What caused your present condition?

- a) No specific injury
- b) Home accident
- c) Work Accident
- d) Auto Accident

What happened to cause your present pain?

Have you ever had these symptoms before?

- a) No
- b) Yes: (Date: _____)

What time of day are your symptoms **better**?

- a) Morning
- b) Afternoon
- c) Evening
- d) None of the above (constant pain)

What time of day are your symptoms **worse**?

- a) Morning
- b) Afternoon
- c) Evening
- d) All of the above (constant pain)

Have you missed any work from this condition?

- a) No
- b) Yes: (Date: _____)

What makes your pain **better**?

- a) Rest
- b) Ice packs/Heating pads
- c) Prescription Medications
- d) Drug store medications (Ibuprofen, Advil)
- e) Other: _____

What makes your pain **worse**?

- a) Activity (work, repetitive motions)
- b) Ice packs/Heating pads
- d) Driving (or riding) in car
- e) Other: _____

What home remedies have you tried?

- a) Ice packs
- b) Heating pads/Hot tubs
- c) Exercise
- d) Other: _____

Please Label The Area(s) Of Today's Pain
(Sharp, Dull, Radiating, Aching, Burning, Numbness)


