

Waterford Chiropractic Office * New Patient Information Worksheet

Name: _____ SS#: _____ Age: _____

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

Home Phone: _____ Work Phone: _____ Birth Date: _____

Employed By: _____ Spouse Name: _____

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

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 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 * Phone: (262) 534-3767

505 Aber Drive * P.O. Box 86
Waterford, WI 53185-0086

Patient's Name _____ Date: _____

(Please circle the number which most closely describes your "Activities Of Daily Living" today)

1. Pain Intensity

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

2. Frequency Of Pain

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Occasional Pain Intermittent Pain Frequent Pain Constant Pain
25% Of The Day 50% Of The Day 75% Of The Day 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
No Restrictions No Restrictions Need to go slowly Need some assistance Need 100% Assistance

4. Travel (Driving, Riding, etc.)

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
On Long Trips On Long Trips On Long Trips On Short Trips On Short Trips

5. Work

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
Can Do Usual Work Can Do Usual Work Can Do 50% Can Do 25% Cannot Work
Plus Extra Work No Extra Work Of Usual Work Of Usual Work

6. Recreation

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
Can Do All Can Do Most Can Do Some Can Do A Few Cannot Do Any
Activities Activities Activities Activities Activities

7. Sleeping

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
Perfect Mildly Moderately Greatly Totally
Sleep Disturbed Disturbed Disturbed Disturbed

8. Lifting

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
With Heavy Weight With Heavy Weight With Moderate Weight With Light Weight With Any Weight

9. Walking

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
Any distance After One Mile After Half Mile After Quarter Mile With All Walking

10. Standing

----- (0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
After Several Hours After Several Hours After One Hour After Half Hour With Any Standing

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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



