CORNERstone
CHIROPRACTIC OF ANTIGO

2006 Progress Blvd. Antigo, WI 54409
(715) 623-5481

WELCOME TO WELLNESS – WE'RE GLAD YOU ARE HERE

Name: ____ Age: __________ Today's Date: ___________

Mailing Address: _________________________________City: ____________________

St: ____ Zip: ______________

SSN#:________________________________ Birth date: _____/_____/_____ No. of Children: ______

Phone (home): ____________________ (cell):____________________ Preferred Contact: Home / Cell / Either

E-Mail: _________________________________ I Am: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Widowed

Employer: ______________________________Occupation:_____________________________________

Emergency Contact/Relationship: ______________________________Phone: _______________________

How did you hear about us? ☐ Location ☐ Doctor ☐ Internet ☐ Ins Co Referral ☐ Friend or Family Member

Who can we thank for referring you? ____

We promise to treat you with respect, compassion, and understanding.

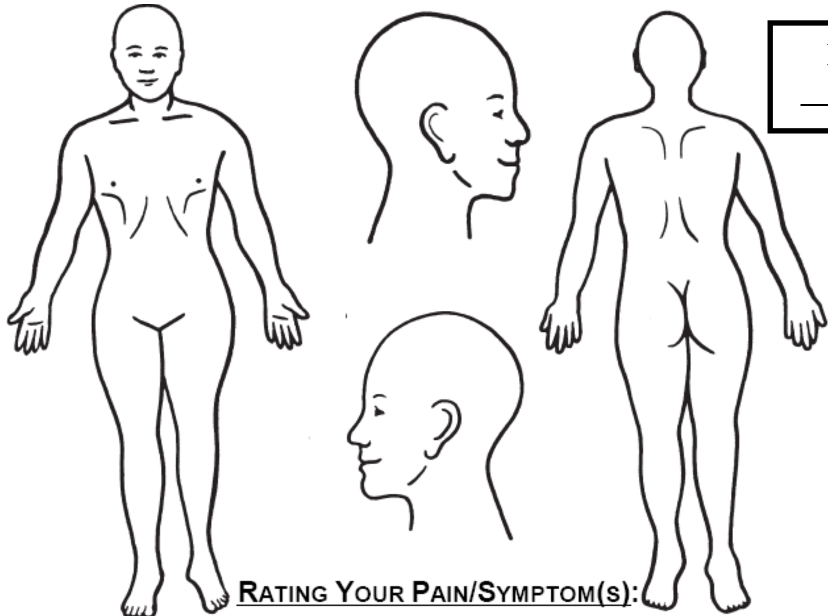
ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

HISTORY OF PRESENT ILLNESS / INJURY

CHIEF COMPLAINT(S)

FILL OUT THIS SECTION AS ACCURATELY AS POSSIBLE. MARK THE AREA WITH THE DESCRIBED SENSATION USING THE APPROPRIATE SYMBOLS FROM THE LEFT.

X X X BURNING PAIN
((((ACHING PAIN
0 0 0 PINS & NEEDLES
- - - - NUMBNESS
: : : : SHARP PAIN



Date of injury: ____________

PLEASE COMPLETE:

____ CONSTANT
____ COME & GO

____ GETTING BETTER
____ GETTING WORSE
____ STAYING SAME

BETTER:		WORSE:
_____	AM	_____
_____	MID-DAY	_____
_____	PM	_____

RATING YOUR PAIN/SYMPTOM(S):

ENTER THE NUMBER THAT BEST REPRESENTS YOUR LEVEL OF DISCOMFORT AS IT APPLIES TO YOU. "0" IS NO PAIN/SYMPTOM(S) "10" IS INTOLERABLE

	NECK (RATE 0-10)	MID BACK (RATE 0-10)	LOW BACK (RATE 0-10)	__________ (RATE 0-10)	________ (RATE 0-10)
NOW:	__________	__________	__________	__________	__________
BEST:	__________	__________	__________	__________	__________
WORST:	__________	__________	__________	__________	__________
USUAL:	__________	__________	__________	__________	__________

What Makes the Condition Better?

Head / Neck ______
Mid Back ______
Low Back ______
Shoulder, Arm, Hand ______
Hip, Leg, Foot ______
Other ______

What Makes the Condition Worse?

Head / Neck ______
Mid Back ______
Low Back ______
Shoulder, Arm, Hand ______
Hip, Leg, Foot ______
Other ______

How Did It Occur? ☐ Work – Related Injury ☐ Auto Accident ☐ Other: ______

When Did They Begin? ______ Have You Missed Work? **Yes No** How Much? ______

Indicate Your Ability to Perform the Following Activities. Please Use the Following Codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

1. _____ Lying on Back	6. _____ Using Stairs/Ladder	11. _____ Sexual Activity	16. _____ Walking
2. _____ Lying on Sides	7. _____ Gripping	12. _____ Getting In / Out of Car	17. _____ Standing
3. _____ Lying on Stomach	8. _____ Pushing / Pulling	13. _____ Sitting/Driving/Riding	18. _____ Bending Forward
4. _____ Turning Over in Bed	9. _____ Reaching	14. _____ Using a Computer	19. _____ Lifting
5. _____ Stooping	10. _____ Dressing Self	15. _____ Kneeling	20. _____ Cough / Sneeze/ Grunt

YES NO

☐ ☐ Does the Discomfort Interfere with your Sleep?
- ♦How Many Times Does It Wake You Up? ______

☐ ☐ Do You Sleep with a Pillow? How Many? ______
- ♦Where? ______
- ♦What Positions Do You Sleep In? ______
- ♦How Old is Your Mattress? ______

☐ ☐ Does Using Heat Affect the Pain? How? ______

☐ ☐ Does Using Cold Affect the Pain? How? ______

☐ ☐ Do You Wear a Heel Lift? Which Side? (**Left** or **Right**)

☐ ☐ Do You Wear Foot Orthotics?

☐ ☐ Have you Had X-Rays of the Problem Area(s)?
- ♦When? ______
- ♦Facility? ______
- ♦Body Part(s)? ______

Females: Are You Pregnant? ☐Yes ☐No

Due Date: ______ Doctor: ______

Date of Last Gynecological & Breast Exam: ______

Males: Date of Last Prostate & Testicular Exam: ______

Neck & Headache Questions

YES NO

☐ ☐ Difficulty Turning Head? ☐ Left ☐Right

☐ ☐ Do You Hear Grating / Crackling Sounds?

☐ ☐ Was There a Feeling of Ripping or Tearing?

☐ ☐ Do You Try to "Crack" Your Own Neck?

☐ ☐ Do You Get Pain or Cracking in Jaw?

☐ ☐ Family History of Headaches?

☐ ☐ Do You have Nausea, Vomiting, Visual Disturbances, Altered Hearing, Ringing in Ears, or Loss of Balance?

☐ ☐ Do You Pain or Pressure Behind the Eye(s)? Rt or Lt

☐ ☐ Do You Have Abnormal Blood Pressure?

♦Frequency of Headaches: ______ per ______

♦Date of Last Eye Exam: ______ . Any Rx Changes? Y or N

Low Back Pain Questions

YES NO

☐ ☐ Does Pain Radiate to the Abdomen and/or Groin?

☐ ☐ Any Impairment of Bowel or Bladder Function?
- ♦Explain? ______

☐ ☐ Was There a Feeling of Ripping or Tearing?

☐ ☐ Do You Try to "Crack" Your Own Back?

Past Medical History

☐ Never ☐ 1-3 Times ☐ 4 or More Times: How Many Times Have You Had the Condition That You Are Seeing Us for Today?

YES NO

☐ ☐ **Do You Suffer From Any Other Health Condition(s)?** (Check All That Apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Asthma ☐ IBS/Colitis ☐ Cancer
☐ Arthritis ☐ Infertility Issues ☐ Others: ______

☐ ☐ **Have You Ever Seen a Chiropractor Before?**

- ♦ When Was the Last Time You Were Seen? ______ Which Dr.? ______
- ♦ For What Problem(s)? ______ Were You Helped? ______
- ♦ How Often Were You Being Seen? ______ Why Did You Leave? ______
- ♦ List Any Other Chiropractors You've Seen in the Past: (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Why Did You Leave?

☐ ☐ **Have You Ever Seen a Medical Doctor for This Condition Before?** (Use More Paper as needed.)

Date	Dr. Name	Condition(s)	Results
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications
			☐ Complete Recovery ☐ Complications

Name: ______ **DOB:** ______

PAST MEDICAL HISTORY - CONTINUED

DOB: ________________

☐ ☐ **DO YOU HAVE ANY ALLERGIES?** IF SO, TO WHAT? ____________________

☐ ☐ **LIST ANY PRESCRIPTION DRUGS, OVER THE COUNTER DRUGS, VITAMINS, AND/OR SUPPLEMENTS:** (USE MORE PAPER AS NEEDED.)

PRODUCT / DRUG	REASON(S)	FREQUENCY	DOSAGE	HELPING?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

☐ ☐ **HAVE YOU ATTEMPTED ANY OTHER SELF CARE REMEDIES TO ALLEVIATE YOUR CONDITION? (E.G. TOPICAL OINTMENTS OR HOME MEDICAL EQUIPMENT SUCH AS BRACES/SUPPORTS, CERVICAL PILLOW, LOW BACK SUPPORT BELT, STRETCHING, EXERCISING, ETC.) IF YES, WHAT?**

____

☐ ☐ **DESCRIBE ANY MAJOR ILLNESSES, INJURIES, FALLS, HOSPITALIZATIONS, AUTO ACCIDENTS, AND/OR SURGERIES:** (USE MORE PAPER AS NEEDED.)

DATE	DR. NAME	CONDITION(S)	RESULTS	
			☐ COMPLETE RECOVERY	☐ COMPLICATIONS
			☐ COMPLETE RECOVERY	☐ COMPLICATIONS
			☐ COMPLETE RECOVERY	☐ COMPLICATIONS

SOCIAL HEALTH HISTORY

GENDER: ☐ MALE ☐ FEMALE STUDENT: ☐ PART-TIME ☐ FULL-TIME ☐ SCHOOL: ____________________

OCCUPATION: ____________________ HRS PER WEEK : ________ YRS ON JOB: ________ YRS WITH EMPLOYER: ________

RECREATIONAL ACTIVITIES / HOBBIES: ____________________

YES NO

☐ ☐ DO YOU EXERCISE? HOW OFTEN? ____________ IN WHAT WAY? ____________

☐ ☐ ARE YOU A SMOKER? HOW MUCH? ____________

HOW MUCH WATER DO YOU DRINK? ____________

☐ ☐ DO YOU CONSUME CAFFEINE? HOW MUCH & HOW OFTEN? ____________

☐ ☐ DO YOU CONSUME ALCOHOL? HOW MUCH & HOW OFTEN? ____________

FAMILY HEALTH HISTORY

LIST ANY CURRENT OR PAST HEALTH CONDITIONS OF YOUR FAMILY MEMBERS. OR IF DECEASED, AT WHAT AGE AND FROM WHAT?

MOTHER: ____________________

FATHER: ____________________

BROTHERS/SISTERS: ____________________ HOW MANY? ________

CHILDREN: ____________________ HOW MANY? ________

SYSTEM REVIEW QUESTIONS

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS NOW OR IN THE PAST? (PLEASE MARK **Y** FOR YES OR **N** FOR NO IN EACH OF THE FOLLOWING:)

1. ____ **EYES** (GLASSES, CONTACTS, CATARACTS, GLAUCOMA, ETC.)
2. ____ **EARS, MOUTH, NOSE, THROAT** (HEARING LOSS, SINUS, ETC.)
3. ____ **CARDIOVASCULAR** (HEART, HIGH B.P., HIGH CHOLESTEROL, ETC.)
4. ____ **RESPIRATORY** (LUNGS, BREATHING, ASTHMA, C.O.P.D., ETC.)
5. ____ **NEUROLOGICAL** (NERVE ISSUES, WEAKNESS, NUMBNESS, ETC.)
6. ____ **ENDOCRINE** (THYROID, HORMONAL IMBALANCES, LIVER, ETC.)
7. ____ **GASTRO-INTESTINAL** (ACID REFLUX, ULCERS, GALL BLADDER, I.B.S., ETC.)
8. ____ **GENITO-URINARY** (MALE/FEMALE REPRODUCTION, KIDNEYS, BLADDER, ETC.)
9. ____ **MUSCULOSKELETAL** (BREAKS, ARTHRITIS, OSTEOPOROSIS, DISCS, ETC.)
10. ____ **SKIN** (RASHES, SKIN CANCER, DRYNESS, PSORIASIS, ECZEMA, HAIR, ETC.)
11. ____ **PSYCHIATRIC** (ANXIETY, DEPRESSION, BIPOLAR, ADD/ADHD, ETC.)
12. ____ **OTHERS**: ____________________

PLEASE DESCRIBE IN MORE DETAIL: ____________________

I certify that I, and /or my dependent(s), have insurance coverage with the above Carrier and assign directly to Cornerstone Chiropractic & Wellness all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Cornerstone Chiropractic & Wellness may use my health care information and may disclose such information to my insurance Carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I hereby authorize the doctors Cornerstone Chiropractic & Wellness to perform an examination, including x-rays if indicated, and to provide chiropractic services to me

____________________ ____________________

Signature of Patient, Parent, Guardian or Personal Representative — Please **Print Name** of Patient, Parent, Guardian or Personal Representative

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