

BAUER CHIROPRACTIC & MUSCLE THERAPY

PATIENT REGISTRATION & HEALTH HISTORY

306 West Cook Street
Portage, WI 53901
(608) 742-2225

Please answer each question completely. Write N/A if not applicable

Date: _____

First Name: _____ MI _____

Last Name: _____

Address: _____

City _____

State _____ Zip _____

Phone: Home (____) _____

Phone: Other (____) _____ Cell Fax

Email Address _____

Date of Birth ____/____/____ Age ____ Male Female

Single Married Divorced Widowed Other

Social Security #: _____ - _____ - _____

Drivers License # _____ State _____

Occupation _____ Employer/School _____ Work (____) _____

Spouse's Name _____ Children's Names and ages if applicable: _____

How did you hear about our office? _____

Please check any and all insurance coverage you have and/or the method of payment applicable, and complete all pertinent information.

Cash Medicare Medicaid Health Insurance Other Auto Accident Worker's Compensation

What is your chief reason for consulting us? _____

Date of first symptom? _____

Is this problem the result of a (check all that apply): Work Comp Injury Motor Vehicle Accident Sports Injury Unknown

Have you been treated for this condition up to this point? (i.e., medications, other doctors, etc.): _____

Do you suffer from any other medical conditions for which you are now consulting us? _____

List current medical doctors: _____

List any medications that you may be taking, including dosage: _____

List previous surgeries (reasons and dates): _____

List previous chiropractors (Names and approximate date of last adjustment): _____

How do you want us to address your condition? Maximum Correction Temporary Relief (Band aid)

DIETARY & NUTRITIONAL HABITS

Do you eat breakfast regularly? Yes No

Do you use artificial sweeteners or foods with artificial sweeteners? Yes No

Do you crave sweets regularly? Yes No

Do you take vitamins? Yes No

If yes, what vitamins do you take, how often, and how much? _____

If you do not take supplements, are you interested in information on supplements? Yes No

Do you: Smoke Tobacco? No Yes If Yes, quantity/day _____

Drink Alcohol? No Yes If Yes, quantity/day _____

Drink Coffee? No Yes If Yes, quantity/day _____

Drink Pop/Soda? No Yes If Yes, quantity/day _____

EXERCISE HABITS

Do you exercise? Yes No If yes, how often? 1-3X/week 3-5X/week 5-7X/week

Do you exercise at: Home or Gym? Please check all activities that you perform: Walk Run Bike Stairstep

Aerobics Weight Train Stretching Exercises Roller Blading Others _____

On a scale of 1-10 (10 being the most, and 1 being the least)

	How would you rate your quality of life right now?
	How committed are you at being / at feeling your best?
	How important is it for your family to be at their optimum health potential?
	How committed would you like me and my staff to be?

What do you like to do for fun? (i.e., sports, hobbies, etc): _____

PAST HISTORY INFORMATION

List all previous falls and other accidents (Date and Describe):

Date	Injury involved in/at:	Description of Accident/Fall/Injury
	Automobile	
	School	
	Recreational Vehicle	
	Sports	
	Other	

WORK DESCRIPTION

ACTIVITY(Please check all that pertain to your workday)	0-33%	33-66%	66-100%
Sitting			
Standing			
Light Lifting (less than 25 pounds)			
Heavy Lifting (greater than 25 pounds)			
Bending			
Telephone			
Chronic repetitive motions			
Driving			

FAMILY HISTORY: Check if any member of your immediate family has/had any of the following:

- Heart Disease
 Diabetes
 Digestive Disorders
 Liver Disease
 Arthritis
 Other List:
 Learning Disabilities
 Stroke
 H/L Blood Pressure
 Lung Disease
 Kidney Disease

INDICATE PROBLEMS THAT APPLY TO YOU: (C = Currently, P = in the Past)

DESCRIPTION	C	P	DESCRIPTION	C	P	DESCRIPTION	C	P	DESCRIPTION	C	P
Dizziness			Stomach Disorders			Rheumatism			Neck Pain/Stiffness		
Sinus Trouble			Thyroid Problems			Diabetes			Hand/Arm Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Lung Trouble			Heart Trouble			Stroke			Shoulder Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Allergies			Kidney Problems			Arthritis			Hip Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Bursitis			Male Problems			Cancer			Leg Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Colitis			Female Problems			HIV/AIDS			Sacroiliac Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Depression			Skin Disorders			Pregnancy			Knee Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Nervousness			Hearing Problems			Low Back Pain			Foot Pain <input type="checkbox"/> R <input type="checkbox"/> L		
Poor Appetite			Eczema			Mid Back Pain			Hand Weakness <input type="checkbox"/> R <input type="checkbox"/> L		
Gas			Numbness			Poor Circulation			Arm Weakness <input type="checkbox"/> R <input type="checkbox"/> L		
Ulcers			Stiffness			Epilepsy			Hand Numbness <input type="checkbox"/> R <input type="checkbox"/> L		
Constipation			Fainting			Headaches/Migraines			Arm Numbness <input type="checkbox"/> R <input type="checkbox"/> L		
Diarrhea			Swelling			Poor Health			Blood Pressure <input type="checkbox"/> H <input type="checkbox"/> L		

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I believe that all information is complete to the best of my knowledge. I will be responsible for any expenses the insurance carrier does not meet. This includes denial of services at any time during treatments that are deemed not medically necessary, considered as maintenance or wellness care by the third party payor. I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are my responsibility. I hereby assign the benefits I am eligible to receive for the care rendered in this office. I authorize the office to release any information, to any insurance company, adjuster or attorney that will assist in payment of claims. A photocopy of this form will be considered as valid as the original.

Patient's Signature _____ Date _____ DC/CA Signature _____