



Stackpool Chiropractic, s.c.

LIFETIME FAMILY WELLNESS

800 Geneva Pkwy Unit 2 • Lake Geneva, WI 53147
(262)248-6700 • www.stackpoolchiropractic.com

Patient History

(Please print, all information is confidential)

Name: _____ Referred by: _____

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

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Email: _____ Sex: M F Marital Status: _____ DOB: _____ Age: _____

of Children: _____ Occupation: _____ Employer: _____

Do you have insurance? Y or N (If yes, please give the front desk your card to copy)

FOR PRESENT CONDITONS MARK AN "X", PAST CONDITIONS MARK A "P"

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Fractured bones | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hearing loss R L | <input type="checkbox"/> High/Low blood press. |
| <input type="checkbox"/> Auto accidents | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Fainting | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> ___ 0-1yrs ago | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> ___ 1-5 yrs ago | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Blurred vision R L | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> ___ more than 5 | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Double vision R L | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Other accidents/falls | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Upper back pain/stiff | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Back curvature | <input type="checkbox"/> Headache | <input type="checkbox"/> Mid back pain/stiff | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pain/Stiff neck R L | <input type="checkbox"/> Low back pain/stiff | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness/Tingle/Pain | <input type="checkbox"/> Numbness/Tingle/Pain | <input type="checkbox"/> Colon trouble |
| <input type="checkbox"/> Swollen/Painful joints | <input type="checkbox"/> - arms/hands/fingers R L | <input type="checkbox"/> in buttocks, thighs, legs, feet, toes | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Jaw pain/TMJ R L | <input type="checkbox"/> Pain w/ cough/sneeze | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Head/Shoulders tired | <input type="checkbox"/> Hip pain R L | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Difficulty in excessive | <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> (Standing, walking, bending, | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> riding, twisting, lifting, | <input type="checkbox"/> Asthma | <input type="checkbox"/> Menopausal Problems |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> household duties) | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Pregnant (now) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Shoulder pain R L | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Ear infection |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ringing in ears R L | <input type="checkbox"/> Stroke | <input type="checkbox"/> AIDS/HIV |

List all surgeries: _____

What medications, OTC and/or supplements are you taking? _____

Is your visit due to an accident, injury or trauma? Y _____ N _____ If so, was it AUTO _____ Work _____

Describe the events of the accident: _____

Have you seen any other health care providers for this accident, injury or trauma? Y _____ N _____

Who? _____

What treatment did you receive? _____

CONSULTATION/HISTORY REVIEW:

Vertebral Subluxation Interview:

Are you aware that every symptom or condition, which you have listed from the front page, is typically the result of interference in your nerve system or from Subluxation? **Y** _____ **N** _____

Symptoms and pain are the two most common results of Subluxation. Symptoms and pain are usually signals to let the body know something is wrong.

1. Which problem or condition you listed on the front page is worst? _____

Is this the first time or have you experienced this problem in the past? _____

2. How long had this condition been a problem? _____

3. What have you done to relieve your pain and suffering? _____

4. Subluxations can cause different irritation/sensation to the nerve fibers. Describe how your pain feels. (i.e. Sharp, stabbing, numbness, tingling, achy, throbbing, etc. _____

5. Subluxations often put pressure on the spinal cord. Symptoms may come and go over time. Is your condition:

CONSTANT OR INTERMITTENT (circle one)

6. Pressure on the spinal cord can vary throughout the day, is your condition worse in the:

AM PM CONSTANT (circle one)

7. Does your pain ever radiate into your arms or legs or is it local to one area?

ARMS R L LEGS R L STAYS IN ONE AREA (circle one)

8. Is there anything else you can think the doctor should know concerning your condition?

YES _____ NO _____

Thank you for your input. We look forward to helping you discover the benefits of chiropractic.

Patient Signature

Date