



Confidential Patient Information

Coulee Health
920 WI-16 Suite A
West Salem, WI 54669

(608) 498-4669 Phone
(608) 807-5142 Fax
www.couleehealth.com

Date: ____/____/____

Patient's Full Name _____

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

Cell Phone: ____-____-____ Additional Phone: ____-____-____ E-Mail: _____

Male Female Date of Birth: ____/____/____ Married Single Widowed Separated Divorced

Spouse's Name: _____ Number of Children/Ages _____

Currently pregnant: Yes ____ weeks No # of vaginal births: ____ # of Cesarean births: ____

How did you find us?

- | | | |
|--|---|--|
| <input type="checkbox"/> Existing Patient
Name: _____ | <input type="checkbox"/> BIRTHFIT
<input type="checkbox"/> Google
<input type="checkbox"/> Social Media | <input type="checkbox"/> Office Website
<input type="checkbox"/> MPI Website
<input type="checkbox"/> Other Website: _____ |
| <input type="checkbox"/> Physician
Name: _____ | | |
| <input type="checkbox"/> Friend
Name: _____ | | |
| <input type="checkbox"/> Other _____ | | |

Social Security # ____ - ____ - ____

Status: Employed Full Time Student Part Time Student Retired Unemployed Occupation: _____

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: ____ - ____ - ____

Family Physician: _____ City: _____ State: _____ Phone _____

Previous Chiropractic Care: Yes No If Yes, for what Problem: _____

Chiropractor's Name/Location _____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

- You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.
- I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Patient Signature: _____ **Date:** ____/____/____

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

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Present complaint(s): _____

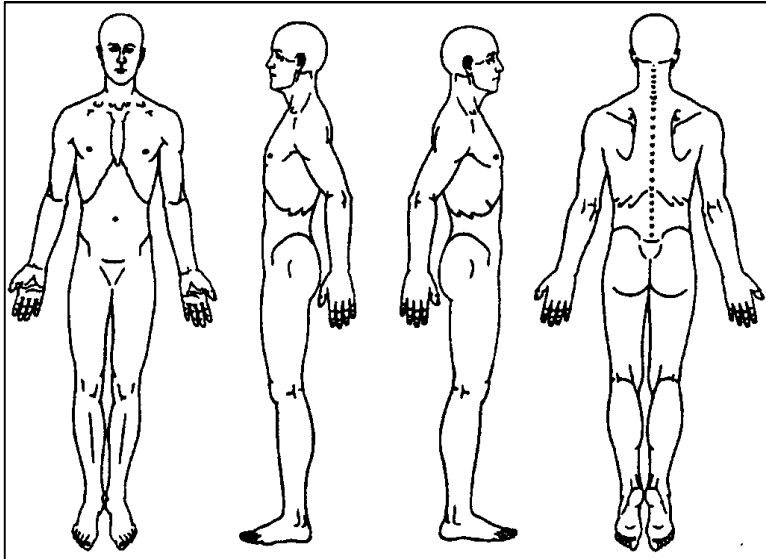
When did your symptoms begin? (Specific date if possible) _____

How did your symptoms begin? (i.e. Lifting, ect.) _____

In the past have you had anything similar to this? Yes No Please explain _____

Please fill out the pain chart below, or select one of the following reasons for your visit:

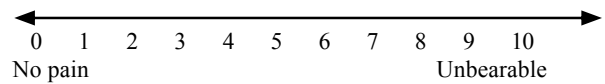
- Pregnancy Diastasis Rectus Abdominis Pelvic Floor Dysfunction Wellness



DESCRIBE YOUR PAIN

#1 Complaint _____

(Rate your level of Pain, Scale 0-10)



Check all that apply to your #1 Complaint

- | | | |
|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Ache | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Soreness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Constricting |

Other _____

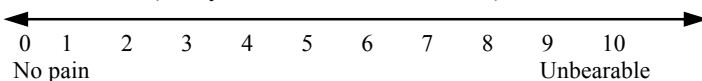
How often are your complaints present?

- | | |
|--|---|
| <input type="checkbox"/> Constant 100% of the time | <input type="checkbox"/> Frequently 75% |
| <input type="checkbox"/> Intermittent 50% | <input type="checkbox"/> Occasional 25% |

DESCRIBE YOUR PAIN

#2 Complaint (if applicable) _____

(Rate your level of Pain, Scale 0-10)



Check all that apply to your #2 Complaint

- | | | |
|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Ache | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Soreness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Constricting |

Other _____

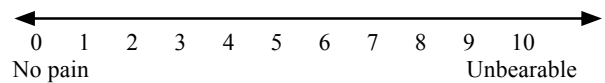
How often are your complaints present?

- | | |
|--|---|
| <input type="checkbox"/> Constant 100% of the time | <input type="checkbox"/> Frequently 75% |
| <input type="checkbox"/> Intermittent 50% | <input type="checkbox"/> Occasional 25% |

DESCRIBE YOUR PAIN

#3 Complaint (if applicable) _____

(Rate your level of Pain, Scale 0-10)



Check all that apply to your #3 Complaint

- | | | |
|-----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Ache | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Soreness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Weakness | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Constricting |

Other _____

How often are your complaints present?

- | | |
|--|---|
| <input type="checkbox"/> Constant 100% of the time | <input type="checkbox"/> Frequently 75% |
| <input type="checkbox"/> Intermittent 50% | <input type="checkbox"/> Occasional 25% |

Is your Pain:

- Increasing
- Decreasing
- Not Changing
- Varies

Was the Onset:

- Gradual
- Sudden

Pain is aggravated by:

- Walking
- Sitting
- Riding in a car
- Standing
- Other _____

- Lifting
- Bending
- Stretching
- Twisting

Pain is improved by:

- Medication
- Rest
- Exercise
- Therapy
- Other _____

- Chiropractic Adjustment
- Ice
- Heat

Yes No Is pain affecting your ability to work or be active? If Yes explain: _____

Yes No Any change in bowel/bladder function, including stress incontinence? If Yes explain: _____



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- Yes No Any fever or chills? If Yes explain: _____
- Yes No Any dizziness associated with symptoms? If Yes explain: _____
- Yes No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain: _____
- Yes No Are your complaints affecting your sleep? If Yes explain: _____
- Yes No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain: _____
- Yes No Any recent falls / accidents / surgeries / broken bones? If Yes explain: _____
- Yes No Have you seen any other physicians in the past 6 months? If Yes explain: _____
- Yes No Have you had any prior treatment, including any physical therapy? If Yes, what treatment? _____
- Yes No Have you been in the hospital or had surgery for any reason? If Yes explain: _____
- Yes No Have you ever been in an accident? If Yes explain: _____

<p>What non-prescription medication are you taking?</p> <p><input type="checkbox"/> Tylenol <input type="checkbox"/> Aspirin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> None <input type="checkbox"/> Other _____</p> <p>How often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____</p>	<p>What Prescription medication are you taking?</p> <p><input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Birth Control Pill <input type="checkbox"/> Nerve Pills <input type="checkbox"/> Pain Killers <input type="checkbox"/> Cholesterol Meds <input type="checkbox"/> HRT <input type="checkbox"/> Muscle Relaxers <input type="checkbox"/> Insulin <input type="checkbox"/> Sleeping Aid <input type="checkbox"/> Blood Pressure Meds <input type="checkbox"/> Thyroid Meds <input type="checkbox"/> Recent Antibiotics</p> <p><input type="checkbox"/> Other _____ <input type="checkbox"/> None Specific names if possible: _____</p>
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- Yes No Do you smoke? If Yes how much?: _____
 If you have quit smoking, when did you quit? _____
- Yes No Do you consume alcohol more than socially?
- Yes No Do you exercise? If Yes what is your routine? _____

Please circle regular dietary intake: fruits vegetables meats grains dairy products nuts/seeds/berries sugars Paleo/Primal gluten-free

What type of care are you interested in: Pain relief only Healing of current condition Optimizing your health All three

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

Mother: _____	Father: _____
Brother(s): _____	Sister(s): _____
Other: _____	Other: _____

Other health concerns? _____