KAISER CHIROPRACTIC, S.C.

790 Gardner Street • Lake Geneva, WI 53147 *Christopher Kaiser, D.C.*

CONFIDENTIAL HEALTH HISTORY

This information is considered strictly confidential. We need this information because we care for your well-being. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Please use a black pen when completing this form. Thank you.

PATIENT INFORMATION:

Name____Date___________________

Name you prefer___________________________________Date of Birth_____/_____/_________ Age_________

Address____ City/State/Zip_________________________________

Home phone ☐ (_______)_________________________ Cell phone ☐ (_______)____________________________

(Please check a box for the best number to easily get a hold of you)

E-mail____ Social Security #______________________________

Occupation______________________ Employer_________________________ Phone(_____)___________________

Ht.______ Wt.______ Gender:☐M ☐F Marital Status:☐Single ☐Married ☐Widowed ☐Divorced No. of children_____

Spouse's name_____________________ Spouse's Employer__________________Phone (_____)_________________

In case of Emergency, please notify______________________________________ Phone (_____)_________________

Previous Chiropractor______________________________Current M.D.___________________________________

Whom may we thank for referring you to our office?____

FAMILY HISTORY: (If you are adopted, please check here and skip to the next section ☐)

Heart Disease ☐Yes ☐No If yes, who?___________________ Cancer ☐Yes ☐No If yes, who?___________________

Stroke ☐Yes ☐No If yes, who?___________________ Diabetes ☐Yes ☐No If yes, who?___________________

High Blood Pressure ☐Yes ☐No If yes, who?___________________ Kidney Disease ☐Yes ☐No If yes, who?___________________

Muscle/Bone/ Nerve Disease ☐Yes ☐No If yes, who?___________________Other____

TRAUMAS, SURGERIES, HOSPITALIZATION:

Have you ever:

Been Hospitalized? ☐Yes ☐No If yes, please explain____

____

Been in an auto accident? ☐Yes ☐No If yes, please explain____

____

Had surgery? ☐Yes ☐No If yes, please explain____

____

Name____

These items below may relate to your current condition. Please check the appropriate box in each section:
"N" for Never: if you have never had this before, **"P" for Past:** if you have ever had this before, or **"C" for Current:** if you currently have this.

GENERAL:

N P C
- ☐ ☐ ☐ Loss of Sleep
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Nervousness
- ☐ ☐ ☐ Weight Loss/Gain
- ☐ ☐ ☐ Allergies
- ☐ ☐ ☐ Anemia
- ☐ ☐ ☐ Diabetes
- ☐ ☐ ☐ Cancer

Type_________________
- ☐ ☐ ☐ Thyroid Disease
- ☐ ☐ ☐ Alcoholism
- ☐ ☐ ☐ Drug Abuse

GASTROINTESTINAL:

N P C
- ☐ ☐ ☐ Change of Appetite
- ☐ ☐ ☐ Poor Digestion
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over Abdomen
- ☐ ☐ ☐ Ulcers
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Liver Problems
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Appendicitis

Date____/____/______

GENITOURINARY:

N P C
- ☐ ☐ ☐ Frequent Urination
- ☐ ☐ ☐ Kidney Disease
- ☐ ☐ ☐ Urinary Infection
- ☐ ☐ ☐ Inability to Control Urination
- ☐ ☐ ☐ Breast Lump or Pain

DIET:
- ☐ I eat fast food, candy, etc. more than 6 times/month.
- ☐ I occasionally eat fast food, candy, etc. 1-5 times/month.
- ☐ It is rare for me to eat fast food, candy, etc.

EARS, EYES, THROAT:

N P C
- ☐ ☐ ☐ Pain in eyes
- ☐ ☐ ☐ Deafness/Difficulty hearing/Ear noises
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Sinus Problems
- ☐ ☐ ☐ Tonsillectomy

Date____/____/______

RESPIRATORY:

N P C
- ☐ ☐ ☐ Difficulty breathing
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Pneumonia

Date____/____/______
- ☐ ☐ ☐ Tuberculosis

CARDIOVASCULAR:

N P C
- ☐ ☐ ☐ Irregular Heartbeat
- ☐ ☐ ☐ High Blood Pressure

Last Reading____/_____
- ☐ ☐ ☐ Pain over Heart
- ☐ ☐ ☐ Ankle Swelling
- ☐ ☐ ☐ Varicose Veins
- ☐ ☐ ☐ Stroke

Date____/____/______

MUSCULOSKELETAL:

N P C
- ☐ ☐ ☐ Neck stiffness/pain
- ☐ ☐ ☐ Low Back pain
- ☐ ☐ ☐ Swollen joints
- ☐ ☐ ☐ Muscle aches/soreness
- ☐ ☐ ☐ Spinal Curvature
- ☐ ☐ ☐ Arthritis

HABITS:

N P C
- ☐ ☐ ☐ Smoking

Packs per day________
- ☐ ☐ ☐ Drinking Alcohol
- ☐ ☐ ☐ Recreational Drug use

WOMEN:

N P C
- ☐ ☐ ☐ Painful Periods
- ☐ ☐ ☐ Excessive Flow
- ☐ ☐ ☐ Irregular Cycle
- ☐ ☐ ☐ Hot Flashes
- ☐ ☐ ☐ Birth Control

Type_________________

MEN:

N P C
- ☐ ☐ ☐ Testicular Swelling/Pain
- ☐ ☐ ☐ Prostate Problems

SKIN:

N P C
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Change in Mole(s)
- ☐ ☐ ☐ Skin Cancer

Type_________________

NEUROLOGIC:

N P C
- ☐ ☐ ☐ Weakness
- ☐ ☐ ☐ Tremors
- ☐ ☐ ☐ Headaches
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Epilepsy
- ☐ ☐ ☐ Numbness/Tingling
- ☐ ☐ ☐ Forgetfulness
- ☐ ☐ ☐ Depression

EXERCISE:

☐ None ☐ 1-3/weekly ☐ 4-6/weekly

COMMON SLEEPING POSITION:

Please check all that apply

☐ Back ☐ Stomach ☐ Side

Please list any medications that you are taking and for what condition (list dosage and amounts) ____________________

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I hereby authorize and direct my insurance benefits to be paid directly to the doctor. Kaiser Chiropractic S.C. is pleased to accept your insurance assignment. However, it must be fully understood that you are fully responsible for any amount not paid by your insurance. I understand that delinquent accounts accumulate at 12% interest annually.
I hereby give permission to Dr. Kaiser to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition.

Patient's Signature_______________________________Date__________________