Pro Health
CHIROPRACTIC & MORE

New Patient Health History

1777 W. Main Street
Sun Prairie, WI 53590
(608) 318-2410

Name:		Today's Date:
Date of Birth:	Age:	☐Male ☐Female
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Email:
Best way to contact you: ☐Call Home ☐Call Cell ☐Text Cell Carrier: _____ ☐Email		
Parent Name (If Minor):	Phone Number:	

Referral Information

How did you hear about our office?

Emergency Information

Emergency Contact:	
Phone:	Relationship:

Current Health Condition

Areas of Complaint or Reason you're being Seen Today:

Describe How it Feels	☐Sharp ☐Dull ☐Throbbing ☐Stiffness ☐Burning ☐Numb ☐Tingling ☐Ache ☐Weak
Pain Level Today	0 1 2 3 4 5 6 7 8 9 10
Pain At it's Worst	0 1 2 3 4 5 6 7 8 9 10
Pain At it's Best	0 1 2 3 4 5 6 7 8 9 10
How often Do you Have Symptoms?	☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day
When are they worst?	☐Morning ☐Afternoon ☐Evening ☐Intermittent ☐Constant
When did symptoms start?	
When did they get worse?	
Has this happened before?	☐No ☐Yes If yes, When?:
When did you have them last?	☐No ☐Yes If yes, When?:
Did a specific injury occur?	☐No ☐Yes If yes, When?:
Did a specific accident occur?	☐No ☐Yes If yes, Explain:
Is this related to a Work Injury?	☐No ☐Yes See Additional Paperwork
Is this related to an Auto Accident?	☐No ☐Yes See Additional Paperwork
Does anything make it better?	☐No ☐Yes If yes, What?:
Does anything make it worse?	☐No ☐Yes If yes, What?:
What Daily Activities does this condition affect? (Circle All that apply)	☐Bending ☐Changing Sit to Stand ☐Child Care ☐Climbing Stairs ☐Computer Use ☐Pet Care ☐Driving ☐Bathing ☐Kneeling ☐Sleep ☐Sitting ☐Standing ☐Housework ☐Reading/Concentration ☐Yard Work ☐Exercise ☐Walking ☐Running ☐Other (Please List)_____

Health History

Have you had any Surgeries?	☐No ☐Yes If yes, Please List:
Are you currently Pregnant?	☐No ☐Yes

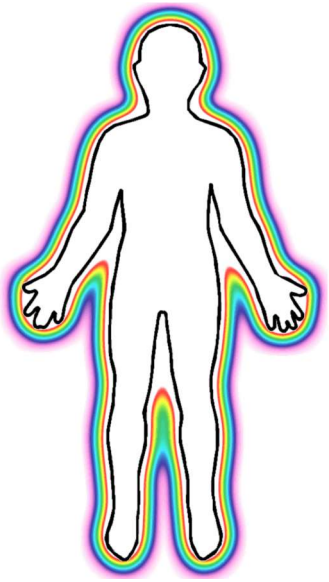
Vaccination History	☐Hepatitis B ☐Rotavirus ☐Diphtheria, tetanus, & acellular pertussis (DTap) ☐Haemophiles Influenzae type B (Hib) ☐Pneumococcal Conjugate (PVC13) ☐Polio ☐Influenza ☐Measles, Mumps, Rubella (MMR) ☐Varicella (Chicken Pox) ☐Hepatitis A ☐Human papillomavirus (HPV) ☐Meningococcal (Meningitis) ☐Meningococcal B (Meningitis B) ☐Pneumococcal polysaccharide ☐Dengue ☐COVID If yes, Please list number of boosters _____
Please Mark If You Have Any Of The Following:	
Skin	☐Rashes ☐Itching ☐Change in Hair/Nails
Head	☐Headaches ☐Head Injury
Eyes	☐Glasses/Contacts ☐Change in Vision ☐Eye Pain ☐Double Vision ☐Flashing ☐Cataracts
Ears	☐Change in Hearing ☐Ear Pain ☐Ear Discharge ☐Ringing ☐Dizziness
Nose/Sinuses	☐Nosebleeds ☐Nasal Stuffiness ☐Frequent Colds ☐Frequent Sinus Infections
Allergies	☐Hives ☐Swelling of lips or tongue ☐Hay Fever ☐Asthma ☐Drub Allergies ☐Food Allergies ☐Other Allergies:
Mouth/Throat	☐Bleeding Gums ☐Sore Tongue ☐Sore Throat ☐Hoarseness
Neck	☐Lumps ☐Swollen Glands ☐Goiter ☐Stiffness
Breast	☐Lumps ☐Pain ☐Discharge
Respiratory/Cardiac	☐Shortness of Breath ☐Cough ☐Wheezing ☐Chest Pain ☐Night Sweats ☐Swelling in hands/feet ☐High Blood Pressure ☐Heart Murmur ☐Emphysema ☐Heart Disease ☐Blue Fingers/Toes
Digestion	☐Change of Appetite ☐Change in Weight ☐Nausea ☐Heartburn ☐Vomiting ☐Constipation ☐Diarrhea ☐Abdominal Pain ☐Belching ☐Food Intolerance
Urinary Tract System	☐Difficulty Urinating ☐Pain/Burning during Urination ☐Urgency ☐Incontinence ☐Dribbling ☐Decreased Stream ☐UTI/Stones/Prostate infection
Musculoskeletal System	☐Pain ☐Swelling ☐Stiffness ☐Decreased Joint Motion ☐Broken Bone ☐Severe Sprain ☐Arthritis ☐Gout ☐Leg Cramps ☐Varicose Veins
Neurologic	☐Headaches ☐Seizures ☐Loss of Consciousness/Fainting ☐Paralysis ☐Loss of Muscle Size ☐Tremor ☐Involuntary Movement ☐Balance Issues ☐Numbness ☐Memory Loss ☐Depression/Anxiety ☐Sleep Problems ☐Change in Mood ☐History of Concussion ☐History of Stroke ☐Difficulty Walking
Hematologic	☐Anemia ☐Easily Bruises ☐Past Transfusions
Endocrine	☐Abnormal Growth ☐Increased Appetite ☐Increased Thirst ☐Increased Urination ☐Thyroid Problems ☐Type 1 Diabetes (Insulin Dependent) ☐Type 2 Diabetes
Medication	Please list all medications & Doses you are currently taking or attach a medication list to this form.
Supplements	If you are currently taking any supplements – please list below or attach a list:

What would you love to be doing that you are unable to do now?	
What would you love to be doing better that you can already do now?	

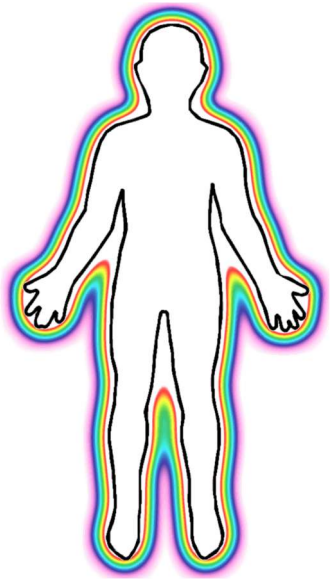
Previous Treatment
Have you seen other providers for this condition? ☐No ☐Yes If yes – Name: _____ Describe Treatment:
AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by the treating doctor, any fees for professional services will be immediately due and payable. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.
Signature: / Date:

Please Circle Areas of Complaint. Use the following letters to describe your symptoms:

S – Stiffness
B – Burning
N – Numbness
P – Sharp Pain
T – Tingling
D – Dull Pain



Front



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