

**BEARD CHIROPRACTIC FAMILY WELLNESS CLINIC**  
**440 E. Albert St., Portage, WI 53901 608-742-2333**

**CONFIDENTIAL PATIENT INFORMATION**

**IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST**

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ M F  
 Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-mail \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Marital Status: M S D W  
 Number of Minor Children \_\_\_\_ Names/Ages \_\_\_\_\_

Your Employer: _____
Employers Address: _____
_____ Work Phone: _____
Occupation: _____ Yrs Employed: _____

Spouse: _____ Date of Birth: _____
Employer: _____
Employer's Address: _____
_____

Person Responsible for this account \_\_\_\_\_ referred by: \_\_\_\_\_

**ABOUT YOUR HEALTH**

The human body is designed to be healthy. Throughout life, events occur which damage your health potential. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

**The following 3 areas can contribute to nerve interference and diminished quality of life.**

**Please circle the letter(s) of the items that apply to you. If unsure leave blank.**

**C=Child T=Teenager A=Adult N=Not at all**

<u>Physical Stress</u>		<u>Emotional Stress</u>		<u>Chemical Stress</u>	
Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip / Fall	C T A N	Career	C T A N	Smoker	C T A N
Posture	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Car Accident	C T A N	Money	C T A N	Caffeine	C T A N
Sports Injury	C T A N	Fast Paced Life	C T A N	Artificial Sweeteners	C T A N
Physical Abuse	C T A N	Hold in Feelings	C T A N	Prescription Drugs	C T A N
Work Injury	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on Wallet	C T A N	Perfectionist	C T A N	Self Medicate	C T A N
Stomach Sleeper	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Computer Work	C T A N	Loss of Loved One	C T A N	Alcohol	C T A N
Repetitive Lift/Bending	C T A N				
Prolonged Driving	C T A N				
Prolonged Standing	C T A N				
Prolonged Sitting	C T A N				
Surgery/Broken Bones	C T A N				
Lack of Phys. Activity	C T A N				
Excess Phys. Activity	C T A N				

\*What do you feel is the primary stressor in your life?  
 \*Rate (circle) your combined overall level of stress from all sources listed above.  
 No Stress---1---2---3---4---5---6---7---8---9---10---High Stress

## Lifestyle Information

### YOUR LEVEL OF HEALTH IS A GENETIC EXPRESSION OF YOUR LIFESTYLE CHOICES

Please rate your overall health status. Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? \_\_\_\_\_

Will you be healthier 5 years from now than you are today? Y N Not Sure

Have you had previous chiropractic care: Y N If Yes, what was the doctor's name? \_\_\_\_\_

What was the date of your last visit? \_\_\_\_\_

Females: Is there any chance you are pregnant? Y N Date last menstrual period ended? \_\_\_\_\_

### How many servings of the following do you have per week?

Vegetable \_\_\_ Fruit \_\_\_ Soy \_\_\_ Bread \_\_\_ Pasta \_\_\_ Potato \_\_\_ Rice \_\_\_ Egg \_\_\_ Poultry \_\_\_ Meat \_\_\_ Dairy \_\_\_

Nuts/seeds \_\_\_ Coffee \_\_\_ Tea \_\_\_ Pop \_\_\_

How would you rate your nutritional intake? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Do you get heartburn after meals? Y N

Do you supplement your diet? Y N

Do you smoke? Y N If yes, how many cigarettes per day? \_\_\_\_\_

Do you consume alcohol? Y N If yes, how many drinks per week? \_\_\_\_\_

Do you feel energized after meals? Y N

Are you taking any medications? Y N If yes, please list \_\_\_\_\_

Do you have problems with digestion or elimination? Y N

How many bowel movements do you have per day? \_\_\_\_\_

How many meals do you eat a day? \_\_\_\_\_

How many glasses of water do you drink per day? \_\_\_\_\_

### SITTING TO THE SPINE IS WHAT SUGAR IS TO THE TEETH

How many times do you exercise per week? \_\_\_\_\_

What activities do you enjoy? \_\_\_\_\_

What is your energy level in the evening? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your work habits?  Sitting  Standing  Light Labor  Heavy Labor

How do you integrate movement into your day? (Besides regular exercise) Check all that apply.

Use stairs instead of elevator  Lifting  Take regular breaks to move around

Walk during lunch  Sit on a ball  Stretches  other \_\_\_\_\_

**WHERE YOU FIND YOURSELF TOMORROW IS A FUNCTION OF THE POSITIVE DECISIONS  
AND ACTIONS YOU TAKE TODAY.**

**Please rate yourself on a scale of 1 – 10 with 10 being the highest.**

When I wake up in the morning, I feel optimistic about the day. 1 2 3 4 5 6 7 8 9 10

I have adequate time to myself. 1 2 3 4 5 6 7 8 9 10

I feel loved and appreciated. 1 2 3 4 5 6 7 8 9 10

Do you get frustrated in bad traffic? Y N

How many hours a day do you watch TV? \_\_\_\_\_

Do you feel exhausted or energized at the end of the day? \_\_\_\_\_

What is your stress level? Low Medium High Why? \_\_\_\_\_

What is the length and quality of your sleep? \_\_\_\_\_hrs/night I sleep: easily restlessly

Is there anything else you would like the doctor to know about your health or your lifestyle?

\_\_\_\_\_

\_\_\_\_\_

**IF YOU ARE HERE FOR WELLNESS CARE ONLY, GO DIRECTLY TO “PAYMENT INFORMATION”.**

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINT (Worst problem first):**

- |          |   |  |
|----------|---|--|
| 1. _____ | Worse in: <input type="checkbox"/> AM <input type="checkbox"/> PM | Pain: <input type="checkbox"/> Is Constant <input type="checkbox"/> Comes & Goes |
| 2. _____ | Worse in: <input type="checkbox"/> AM <input type="checkbox"/> PM | Pain: <input type="checkbox"/> Is Constant <input type="checkbox"/> Comes & Goes |
| 3. _____ | Worse in: <input type="checkbox"/> AM <input type="checkbox"/> PM | Pain: <input type="checkbox"/> Is Constant <input type="checkbox"/> Comes & Goes |
| 4. _____ | Worse in: <input type="checkbox"/> AM <input type="checkbox"/> PM | Pain: <input type="checkbox"/> Is Constant <input type="checkbox"/> Comes & Goes |

Symptoms developed from?

Job related injury  Auto accident  Other Injury  Illness  Gradual onset  Unknown

Date occurred: \_\_\_\_\_ How occurred: \_\_\_\_\_

Have had symptoms for # \_\_\_\_\_Hr(s) \_\_\_\_\_Day(s) \_\_\_\_\_Wk(s) \_\_\_\_\_Mo(s) \_\_\_\_\_Yr(s)

Have you ever had this before:  No  Yes When? \_\_\_\_\_

What do you do that makes this problem worse? \_\_\_\_\_

Name and location of doctors previously seen for present conditions(s): \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**

- Bending  Sitting  Reaching  Standing  Turning Head  Lifting  Walking  Lying Down  
 Straining at Stool  Coughing  Sneezing  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**

- Bending  Sitting  Standing  Lying Down  Turning Head  Walking  Chiropractic Adjustments  
 Ice  Heat  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

**PREVIOUS HISTORY:**

Have you been treated by a physician for any health condition in the past year?  No  Yes

Describe Condition: \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

**SURGICAL HISTORY:** 1. \_\_\_\_\_ Date: \_\_\_\_\_  
 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_

**ACCIDENT HISTORY:**  Job  Auto  Other \_\_\_\_\_ Date: \_\_\_\_\_  
 Job  Auto  Other \_\_\_\_\_ Date: \_\_\_\_\_  
 Job  Auto  Other \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL / FAMILY HISTORY** S=Self M=Mother F=Father (Please indicate which conditions have been experienced)

AIDS.....	<input type="checkbox"/>	Convulsions.....	<input type="checkbox"/>	HIV / ARC.....	<input type="checkbox"/>	Poor Circulation.....	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	Kidney Disorder.....	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	Indigestion.....	<input type="checkbox"/>	Bowel Control Loss..	<input type="checkbox"/>	Rheumatic Fever...	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	Dislocated Joints.....	<input type="checkbox"/>	Menstrual Cramps...	<input type="checkbox"/>	Rheumatism.....	<input type="checkbox"/>
Back Pain.....	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	Multiple Sclerosis....	<input type="checkbox"/>	Scarlet Fever.....	<input type="checkbox"/>
Bladder Trouble.....	<input type="checkbox"/>	German Measles.....	<input type="checkbox"/>	Muscular Dystrophy.	<input type="checkbox"/>	Serious Injury.....	<input type="checkbox"/>
Bone Fracture.....	<input type="checkbox"/>	Headaches.....	<input type="checkbox"/>	Neck Pain.....	<input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	Nervousness.....	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>
Chest Pain.....	<input type="checkbox"/>	Reproductive Disord.	<input type="checkbox"/>	Numbness.....	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>
Concussion.....	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Polio.....	<input type="checkbox"/>	Fibromyalgia.....	<input type="checkbox"/>

**Please Check All Symptoms:**

<b>NECK:</b>	<b>HEAD:</b>	<b>MID-BACK:</b>	<b>LOW BACK:</b>	<b>HIPS/LEGS/FEET:</b>	<b>ARMS/HANDS:</b>
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Headache	<input type="checkbox"/> Mid-back Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Buttocks Pain (R-L)	<input type="checkbox"/> Arm Pain
<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Migraine	<input type="checkbox"/> Pn b/w Shlder Blades	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Hip Joint Pain	<input type="checkbox"/> Elbow Pain
<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Feels Heavy	<input type="checkbox"/> Sharp Stabbing		<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Wrist Pain
<input type="checkbox"/> Grinding	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Dull Ache	<b>ABDOMEN:</b>	<input type="checkbox"/> Leg/Feet Symptoms:	<input type="checkbox"/> Hand Pain
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Nausea	<input type="checkbox"/> Pain	<input type="checkbox"/> Pins & Needles
<b>GENERAL:</b>	<input type="checkbox"/> Dizziness		<input type="checkbox"/> Gas	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Numbness
<input type="checkbox"/> Confusion	<input type="checkbox"/> Vision Trouble	<b>SHOULDERS:</b>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Numbness	<input type="checkbox"/> Cold Hands
<input type="checkbox"/> Irritable	<input type="checkbox"/> Ringing Ears	<input type="checkbox"/> Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cramps	<input type="checkbox"/> Swollen Hands
<input type="checkbox"/> Depressed		<input type="checkbox"/> Can't Raise Arm		<input type="checkbox"/> Cold Feet	
<input type="checkbox"/> Fatigue	<b>CHEST:</b>	<input type="checkbox"/> Shoulder Ht.	<b>MEN ONLY:</b>	<input type="checkbox"/> Swollen Ankles	<b>WOMEN ONLY:</b>
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Over Head	<input type="checkbox"/> Urinary Pain		<input type="checkbox"/> Menstrual Pain
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Frequent Urination		<input type="checkbox"/> Cramps/Irregular
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rib Pain		<input type="checkbox"/> Difficulty Starting		<input type="checkbox"/> Birth Control
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Breast Pain		<input type="checkbox"/> Night Urination		<input type="checkbox"/> Menopause

**PAYMENT INFORMATION:**

**I Have Insurance.**

I authorize direct payment of medical benefits, from my insurance company, to Danny R. Beard, D.C. or supplier for any services performed in his office. I also authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party that accepts assignment.

It is understood that all reasonable efforts will be made to collect from my insurance company before I will be responsible for this. I do understand that any and all amounts which are not collectable from my insurance company shall become my responsibility and I agree to pay those charges within 30 days. I further agree that any insurance reimbursement check received by me which funds is owed to Dr. Beard shall be transferred to Dr. Beard in full amount within 10 days of my receipt of the check.

If I owe a deductible or co-payment for my treatment, I agree that I shall make all reasonable efforts to pay for that at the time of service. If that is not possible I shall discuss the matter with the office staff.

**I Will be Paying Cash/Check/Credit Card.**

Due to my circumstances, I will be receiving a discounted fee which is less than the usual and customary charge for chiropractic care in Dr. Beard's office. In order to keep in compliance with Wisconsin's insurance laws, this "Prompt Payment Discount" must be paid on the same day the services are rendered and no insurance will be billed. Any services not paid for on the same day will have to be charged our normal rates. Exceptions will only be made in emergency situations, with prior notification to our office.

**I have read/received the "Notice of Privacy Policy" and agree to its terms.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_