Dietrich Chiropractic, SC

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Wisconsin Rapids, WI 54495
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John B. Dietrich II, DC
Certified Chiropractic Sports Practitioner
Certified Strength and Conditioning Specialist

Welcome!

Thank you for choosing Dietrich Chiropractic, SC for your health care needs. We want your experience at our clinic to be efficient and enjoyable. Please take the time to complete the enclosed paperwork as thoroughly as possible. This will ensure that your first visit with the doctor will go smoothly.

Please make sure to bring your insurance cards with you for your appointment and a list of any medications you may be taking or surgeries you have had as well.

If you have any questions, please give us a call.

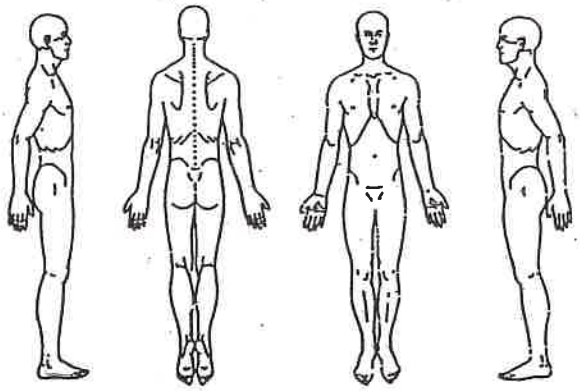
Thank you and have a great day!

Dr. John and the staff at Dietrich Chiropractic, SC

Symptoms Questionnaire

Patient Name _____ **Age** _____ **Today's Date** ____/____/_____

Mark on the picture where you have pain or other symptoms using the symbols below:



Stabbing/Sharp Pain: **/////**
Stiffness: **#####**
Aching Pain: **ccccc**
Burning: **xxxxx**
Numbness: **ooooo**

Below is a pain scale to rate the severity of your problems. Please note the area of pain and circle the appropriate number next to it.

Areas of Complaint: **No Pain = 0 Excruciating Pain = 10**

A. _____ **0 1 2 3 4 5 6 7 8 9 10**

- *What makes your problem worse?*
  ☐nothing ☐lying down ☐sitting ☐standing ☐walking ☐inactivity ☐movement or exercise ☐Other _____
- *What makes your problem better?*
  ☐nothing ☐lying down ☐sitting ☐standing ☐walking ☐inactivity ☐movement or exercise ☐Other _____

B. _____ **0 1 2 3 4 5 6 7 8 9 10**

- *What makes your problem worse?*
  ☐nothing ☐lying down ☐sitting ☐standing ☐walking ☐inactivity ☐movement or exercise ☐Other _____
- *What makes your problem better?*
  ☐nothing ☐lying down ☐sitting ☐standing ☐walking ☐inactivity ☐movement or exercise ☐Other _____

C. _____ **0 1 2 3 4 5 6 7 8 9 10**

- *What makes your problem worse?*
  ☐nothing ☐lying down ☐sitting ☐standing ☐walking ☐inactivity ☐movement or exercise ☐Other _____
- *What makes your problem better?*
  ☐nothing ☐lying down ☐sitting ☐standing ☐walking ☐inactivity ☐movement or exercise ☐Other _____

Frequency of Complaint: ☐Constant(76-100%) ☐Frequent(51-75%) ☐Occasional(26-50%) ☐Intermittent (25%or less)

- *Since your problem began, is the pain:* ☐Increasing ☐Decreasing ☐Not changing
- *Symptoms are worse* in the ☐morning ☐afternoon ☐night ☐increases during the day ☐same all day
- *When did your problem begin?* (Specific date if possible) _____
  ☐immediately after a specific incident ☐multiple incidents ☐gradually over time ☐no specific reason
  Describe how your problem began: _____

_____

- *Are you being treated for this episode?* ☐No ☐Yes, by _____
  My next appointment is ____/____/_____ What is the treatment? _____
- **In the past** have you been treated for this or a similar condition? ☐No ☐Yes, by _____
  When? ____/____/_____ What treatment? _____
- *How would you rate your current level of stress?* ☐No stress ☐Minimal stress ☐Moderate stress ☐Greatly stressed
- *General physical activity:* ☐No regular exercise ☐Light exercise ☐Moderate exercise ☐Strenuous exercise
- *Occupation:* _____ ☐Full time ☐Part time *Physical activity at work:*
  ☐Sit more than 50% of workday ☐Repetitive motion ☐Light manual labor ☐Manual labor ☐Heavy manual labor
- *How do your complaints affect your daily activities?* ☐No effect ☐ Some restrictions ☐Need limited assistance
  ☐Need assistance often ☐Significant inability to function without assistance ☐Totally disabled

(Confidential)

Health History

Patient Name _____ Date _____

Age _____ Birthdate _____ Date of last physical exam: _____

Symptoms

Check (√) conditions you currently have or have had.

MUSCULOSKELETAL

PAST	NOW	
☐	☐	Neck pain
☐	☐	Headache
☐	☐	Upper back pain
☐	☐	Shoulder pain
☐	☐	Pain in upper arm or elbow
☐	☐	Wrist pain
☐	☐	Hand pain
☐	☐	Low back pain
☐	☐	Pain in upper leg or hip
☐	☐	Pain in lower leg or knee
☐	☐	Pain in ankle or foot
☐	☐	Jaw pain
☐	☐	Swelling /stiffness of joints

GENERAL

☐	☐	Change in weight
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fever
☐	☐	Loss of sleep
☐	☐	Numbness

CARDIOVASCULAR

PAST	NOW	
☐	☐	Aortic Aneurysm
☐	☐	Chest pain/Angina
☐	☐	Heart attack/stroke
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Poor circulation
☐	☐	Irregular heart beat
☐	☐	Rapid heart beat
☐	☐	Swelling of ankles
☐	☐	Varicose veins

EYE, EAR, NOSE, THROAT

☐	☐	Bleeding gums
☐	☐	Blurred vision
☐	☐	Difficulty swallowing
☐	☐	Double vision
☐	☐	Earache
☐	☐	Hay fever
☐	☐	Loss of hearing
☐	☐	Nosebleeds
☐	☐	Persistent cough
☐	☐	Ringing in ears
☐	☐	Sinus problems
☐	☐	Visual disturbances

GASTROINTESTINAL

PAST	NOW	
☐	☐	Bloating
☐	☐	Bowel changes
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive hunger
☐	☐	Excessive thirst
☐	☐	Gas
☐	☐	Hemorrhoids
☐	☐	Indigestion
☐	☐	Nausea
☐	☐	Poor appetite
☐	☐	Stomach pain
☐	☐	Vomiting

GENITO-URINARY

☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Lack of bladder control
☐	☐	Painful urination

WOMEN only

☐	☐	Extreme menstrual pain
☐	☐	Hot flashes
☐	☐	Irregular menstrual flow
☐	☐	Other_____

Conditions

Check (√) conditions you currently have or have had.

PAST	NOW		PAST	NOW		PAST	NOW		PAST	NOW	
☐	☐	Acid Reflux	☐	☐	Cancer	☐	☐	Hernia	☐	☐	Pneumonia
☐	☐	AIDS	☐	☐	Chemical dependency	☐	☐	High Cholesterol	☐	☐	Polio
☐	☐	Alcoholism	☐	☐	Chicken Pox	☐	☐	HIV positive	☐	☐	Prostate problem
☐	☐	Anemia	☐	☐	Depression	☐	☐	Kidney disease	☐	☐	Rheumatic Fever
☐	☐	Anorexia	☐	☐	Diabetes	☐	☐	Liver disease	☐	☐	Scarlet Fever
☐	☐	Anxiety	☐	☐	Emphysema	☐	☐	Measles	☐	☐	Scoliosis
☐	☐	Appendicitis	☐	☐	Epilepsy	☐	☐	Migraine headaches	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Fibromyalgia	☐	☐	Miscarriage	☐	☐	Thyroid problem
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Mononucleosis	☐	☐	Tonsillitis
☐	☐	Bleeding disorders	☐	☐	Goiter	☐	☐	Multiple Sclerosis	☐	☐	Tuberculosis
☐	☐	Breast lump	☐	☐	Gout	☐	☐	Mumps	☐	☐	Typhoid Fever
☐	☐	Bronchitis	☐	☐	Heart Disease	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Bulimia	☐	☐	Hepatitis						

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____

Phone _____

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following: Disease	Relationship to You
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical dependency	
					☐ Diabetes	
					☐ Heart Disease, Stroke	
Sisters					☐ High blood pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

Hospitalizations/Surgeries/Broken Bones

Year	Reason for Hospitalization or Surgery & Outcome

Pregnancies

	Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (√) which substances you use and describe how much you use.

☐ Caffeine	
☐ Tobacco	
☐ Alcohol	
☐ Other	

Disability Ratings

Do you have a permanent disability rating? ☐ YES ☐ NO

If yes, location _____

Date rating was received _____

Percentage of rating _____

Patients age 65+ Have you had a pneumonia vaccine? Yes No

Women patients age 50+ Have you had a mammogram? Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature Date

_____

Reviewed By Date

Patient Confidential Information

Full Name: _____ Date: _____
First MI Last

Address: _____
City State Zip

Home phone: _____ Cell phone: _____ Work phone: _____

Age: _____ Date of Birth: _____ Email address: _____

Driver's License #: _____ **OR** Social Security #: _____

Employer & Occupation: _____ Full time / Part time

Marital Status: Married Single Widow/Widower Divorced Number of Children: _____

Spouse **or** legal guardian: _____ Employer: _____

Address: _____
City State Zip

Nearest relative **not** living with you: _____ Relationship: _____

Phone: _____ Address: _____

Insurance Information

Primary Insurance: _____ Policy # _____ Group # _____

Primary Policy Holder: _____ Date of Birth: _____

Secondary Insurance: _____ Policy # _____ Group # _____

Secondary Policy Holder: _____ Date of Birth: _____

Who is responsible for paying this bill? _____

Address to be billed: _____

*Is this a **work-related** injury that would be covered by your **Workers Comp. Insurance**? _____ Y _____ N

*Is this a **personal injury/auto accident** case? _____ Y _____ N

Name of Work Comp./Auto Insurance Comp. _____

Insurance payments are between the patient and the insurance company. We will file the claims, but the patient is liable for payment.
Examination and x-rays that may be needed for diagnosis and treatment of **Medicare** patients **ARE NOT** covered by **Medicare**.

Office Use Only

Signature: _____ X-ray # _____

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HIPAA Compliance Forms:

By signing this form, I acknowledge that I have been given the following HIPAA compliance forms supplied by Dietrich Chiropractic, SC:

1. Consent for Use or Disclosure of Health Information
2. Appointment Reminders and Health Care Information Authorization
3. Chiropractic Society of Wisconsin Authorization
4. Dietrich Chiropractic, SC Notice of Privacy practices

For those patients with Health Insurance:

I acknowledge that Dietrich Chiropractic, SC will be billing my insurance company on my behalf for the services that were provided. By signing this form, I hereby authorize Dietrich Chiropractic, SC to receive payments from my insurance company for those services.

For those patients with Medicare Health Insurance:

I acknowledge that Dietrich Chiropractic, SC will be billing my insurance company on my behalf for the services that were provided. By signing this form, I hereby authorize Dietrich Chiropractic, SC to receive payments from my primary and secondary insurance company for those services.

Name Printed Signature Date

Dietrich Chiropractic, SC
Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ **Last Name:** _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/___ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker/Occasional Smoker/Former Smoker /Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☒ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Heart Rate _____