



**HELLENBRAND
RABIDEAUX
CHIROPRACTIC**

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 Waunakee, WI 53597
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Personal Information

NAME: _____ D.O.B.: _____ AGE: _____ DATE: _____

ADDRESS: _____

CITY.STATE/ZIP: _____

PHONE #: _____ CELL #: _____ WORK #: _____

EMAIL ADDRESS: _____ MALE _____ FEMALE _____

OCCUPATION: _____ EMPLOYERS NAME: _____

MARITAL STATUS: Single Married Divorced Widowed SPOUSE: _____

CHILDREN: Yes No IF YES, NAMES AND AGES: _____

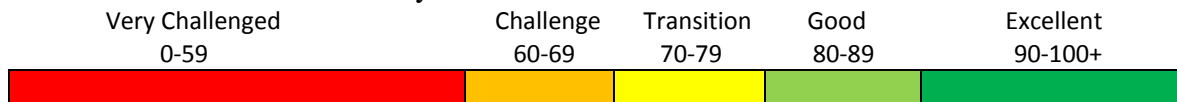
WHO MAY WE THANK FOR REFFERING YOU TO OUR OFFICE? _____

Current Health Information

This form is very important to us. First it will allow us to address the issues that brought you into this office. Second, it will allow us to offer you the opportunity to improve your overall health and wellness for the future. By filling out this form thoroughly, it will give us a better understanding of the level of stress you are experiencing in your daily life. Each one of us experiences physical, chemical and emotional stress every day. These stresses can accumulate and deteriorate our health gradually over time. This form will allow us to better assess your current health as well as the challenges keeping your from reaching your full health potential.

Place an "X" where you think you are on this scale right now?

Place a "O" on the scale where you would like to be.



What brought you into the office? If you have no symptoms and are here for wellness chiropractic services, indicate wellness below.

Health concern:	Severity: 1-10 1=mild 10=extreme	When did it start?	Is the symptom constant or intermittent?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

If you are experiencing pain, is it: Sharp Dull Achy Throbbing

Does your pain radiate or travel anywhere: No Yes – please describe

Has this problem been getting: Worse Better Staying the same

Does anything make you feel worse? _____

Does anything make you feel better? _____

Have you tried anything to make you feel better that was of no help? _____

Is this condition effected your: Work Sleep Exercise Recreational Activities

Mood Family life Other: _____

Have you ever seen a chiropractor before? No Yes – if yes:

Name: _____ Date of last treatment: _____

Have you seen anyone else for this condition? Chiropractor Medical Doctor

Name: _____ Date: _____

What was done? _____

What was the diagnosis? _____

Name: _____ Date: _____

What was done? _____

What was the diagnosis? _____

Is there any chance you might be pregnant? No Yes Date of last period: _____

General Health Information

List any medications you are taking and why: (prescription and non-prescription)

List any allergies you have: _____

Please check all symptoms you have experienced, even if they do not seem related to your current condition:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in neck | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stiffness in neck | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Pain in back | <input type="checkbox"/> Tingling in fingers | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Stiffness in back | <input type="checkbox"/> Tingling in toes | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Irritability | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Menstrual irregularity |

Have you had any surgeries:

1. Type: _____ Date _____
2. Type: _____ Date _____
3. Type: _____ Date _____
4. Type: _____ Date _____
5. Type: _____ Date _____

Have you been in any accidents or injuries: (auto, work, other)

1. Type: _____ Date _____
2. Type: _____ Date _____
3. Type: _____ Date _____
4. Type: _____ Date _____
5. Type: _____ Date _____

Have you had x-rays taken? If yes, When _____ Where _____

What area of the body _____

- Please check yes or no:
- | | |
|--|--|
| Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you drink alcohol more than socially? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you been in any accidents? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any surgeries? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you play any sports? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you exercise regularly? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list your top three stresses in each area:

Physical stress (falls, accidents, posture, etc.)

1. _____
2. _____
3. _____

Chemical stress (smoking, drinking, unhealthy foods, drugs, etc.)

1. _____
2. _____
3. _____

Emotional stress (work, financial, relationships, etc.)

1. _____
2. _____
3. _____

On a scale of 1-10 (1=very poor 10=very good), please rate your:

Eating habits: _____ Exercise habits: _____ Sleep habits: _____

Family Health Information

In our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list their names and any health conditions or concerns they might have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother: _____

Sister: _____

Other: _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that I am responsible for my bill and that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Thank you for taking the time to fill out this form in its entirety and for choosing

Hellenbrand Rabideaux Chiropractic.