Raschke Chiropractic Center, S.C.
Preventive Family Health Care
Fred W. Raschke, D.C.

Welcome to our Health Center

Dear Patient: Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Patient Information

Name: _____ Date: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Cell Phone _____
Employer: _____ Work Phone: _____
Occupation: _____ Social Security #: _____
Birth-date: _____ Age: _____ Height: _____ Weight: _____
Marital Status: _____ Spouse's Name: _____ Children: Yes No How many? _____
Primary Care Physician: _____Phone: _____
Who referred you to our office? __ Ad __ Billboard __ Family/Friend Name _____
Email: _____ __ Yellow Pages __ Another Doctor Name _____

Preferred language: English ___ Other _____

Race: (circle) White Hispanic or Latino Race_____

History

List the problems or concerns you want us to address starting with the most important. (Please rate your pain today with 0 being no pain and 10 being the worst pain.)

1. _____ Pain Number: _____
2. _____ Pain Number: _____
3. _____ Pain Number: _____

When did the primary problem start? (Exact date if possible) _____
What brought it on? _____
_____
What activities or positions significantly **worsen** your symptoms?
___ Cough/Sneeze ___ Sitting/Rising ___ Standing ___ Walking ___ Lifting
___ Lying ___ Other _____ ___ a.m. ___ p.m. ___ As the day progresses
What activities or positions significantly **improve** your symptoms?
___ Nothing ___ Sitting ___ Standing ___ Ice ___ Heat ___ Exercise ___Rest
___Other _____ ___ a.m. ___ p.m. ___ As the day progresses
How often do your symptoms occur? ___ Constant ___ Frequently ___ Intermittently___ Occasionally ___ Other _____
Are you getting…___ Better ___ Worse ___ Staying the same Are you off of work? Yes No
Did you ever have problems in this area before? Yes No
If yes, when and number of episodes? _____
_____
Since your symptoms began, have you noticed a change in ___ Bowel function ___ Gait
___Bladder function ___ Sexual function Onset date? _____ Duration? _____

Medical History

What other physicians (M.D.'s, and D.C.'s) have you seen for this problem?

Name Specialty Date Seen

_____

_____

What tests were done?

Name of test and area studied	Date	Where done	Results
( ) X-ray:			
( ) MRI/CT Scan:			
( ) Bone Scan:			
( ) Other:			

What medications were prescribed for this problem?

Name & Dosage	Much help	Little help	No help
_____	_____	_____	_____
_____	_____	_____	_____

What treatment/therapy has been done for this problem?

___ Ice ___ Heat	_____	_____	_____
___ Exercise	_____	_____	_____
___ Massage	_____	_____	_____
___ Electrical Stimulation	_____	_____	_____
___ Injections	_____	_____	_____
___ Chiropractic Adjustment	_____	_____	_____

Past Medical History

Have you been diagnosed with any other medical problems? (Check all that apply)

___ High blood pressure	___ Seizures	___ Easy bleeding
___ Diabetes	___ Tuberculosis	___ Blood clots
___ Cancer	___ Emphysema or asthma	___ Depression
___ Rheumatoid arthritis	___ Heart attack or angina	___ Anxiety disorder
___ Arthritis	___ Irregular heart beat	___ Mental illness
___ Gout	___ Abnormal heart valve	___ Addiction to alcohol / drug
___ Thyroid disease	___ Aortic aneurysm	___ HIV/AIDS
___ Tension headaches	___ Poor circulation	___ Major trauma (accidents, falls)
___ Migraine headaches	___ Ulcers in stomach or intestines	___ Broken bones
___ Stroke or TIA	___ Kidney problems	___ Severe head injury
___ Liver problems	___ Osteoporosis	___Bowel problems
___Sleep apnea	___Insomnia	___Chronic Fatigue
___ Brain aneurysm	___Lyme's Disease	___Digestive problems
___ Other _____		

Red flag check list for over 50

___Prolonged Corticosteroid use	___Unexplained weight loss	___Pain that does not improve with rest
___Progressive weakness in legs	___Urinary retention or incontinence	___Failure to respond to previous care
___None of these apply		

Please list previous **surgeries** Reason Date Performed

_____

_____

_____

Please list previous **accidents & hospitalizations**

_____

_____
_____

Please list all **medications** that you presently take (prescription & non-prescription)

Medication	Strength	Frequency

Please list any nutritional supplements that you are presently take:

_____
_____
_____
_____

Allergies: Yes or No

Medicine: _____ Severity: mild mod severe Reaction: _____
Medicine: _____ Severity: mild mod severe Reaction: _____
Medicine: _____ Severity: mild mod severe Reaction: _____
Food: _____ Severity: mild mod severe Reaction: _____
Environmental: _____ Severity: mild mod severe Reaction: _____

Personal / Social History

Please list your **hobbies**:

_____
_____

Do you **exercise** regularly? Yes No If so, what? _____
Are you **pregnant**? Yes No
Do you use **tobacco**? Yes No
Smoking status: Current everyday # of years __ Former smoker # of Years since cessation__
Packs per day_____
Current someday never smoked
Packs per day_____

How many glasses of **water** do you drink per day? _____
Do you drink **caffeinated beverages**? Yes No ___ Cups/Cans of Coffee, Tea, Soda
Do you drink **alcoholic beverages**? Yes No Occasionally ___ # of drinks per day
Which of the following best describes your **stress level**? ___ Low ___ Moderate ___ Great
Do you feel that stress is affecting your health? Yes No

Do you **sleep** well? Yes No Number of hours per night _____
What type of **mattress** do you sleep on? ___ Firm ___ Soft ___ Waterbed Other _____
What type of **pillow** do you sleep with? ___ Feather ___Foam ___Fiberfill ___Orthopedic
What **position** do you sleep in? ___ Side ___ Back ___ Stomach
Do you wear **arch supports or orthotics**? Yes No If yes, what? _____
Do you wear your **seatbelt** in the car? Yes No Sometimes

Family History

What diseases run in your family? Father(**F**) Mother(**M**) Brother(**B**) Sister(**Si**) Son(**S**) Daughter(**D**) Unknown(**U**)

_____ Diabetes _____ Cancer _____ Heart disease _____ Stroke
_____ Depression _____ Reaction to anesthesia _____ Arthritis_____ Rheumatoid Arthritis _____
High Blood Pressure_____ Other _____ Unknown_____

Education & Occupation Information

How many years of school did you complete? _____
What is your job title? _____ Are you: ( ) Full-time ( ) Part-time
How many hours per day do you work? _____ Days per week? _____
How long have you worked at your present job? _____Years _____Months
Does your job require you to frequently lift objects? Yes No
If yes, what is the heaviest load frequently lifted? _____
What is your primary work position? _____
Does work aggravate your present complaint? Yes No
Is there anything else you would like us to know about your health? Yes No
If yes, please explain_____

_____

I acknowledge that I have been given a copy of the *Notice of Privacy Practices* document on _____ (date),
_____ (signature)

Thank you for completing this questionnaire. Guardian's signature is required if under 18 years of age. Signature implies consent to treatment.

_____ _____
Signature Date

_____ _____
Doctor's Signature Date