Pivonka Health & Wellness
CHIROPRACTIC | PHYSICAL THERAPY | MEDICINE

Name_____ **Nickname** _____**How did you hear about us** _____

Address_____**City**_____**State**_____**Zip**_____

Cell Phone _____**Home Phone** _____ **SSN**_____

Home Email_____ **Date of Birth**_____ **Age**_____ **Gender** ❑Male❑Female❑Unspecified

Emergency Contact:_____**Contact Phone #**_____

Marital Status ❑Single❑Married❑Other **Children** ❑ YES ❑ NO How Many_____

Employment Status ❑ Employed ❑ FT Student❑ PT Student❑ Other❑ Retired❑ Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

Do you have insurance? ❑Yes ❑No **Insurance Name:**_____

Primary insured?❑Yes ❑No **If no, primary insured name and relationship to self:** _____Their DOB_____

Family Physician _____ **Phone** _____

Current medications. COMPLETE FULLY:

RX Medication/Over The Counter	Dosage	Frequency	Circle how taken
1)			Orally Topically Injectable
2)			Orally Topically Injectable
3)			Orally Topically Injectable
4)			Orally Topically Injectable
5)			Orally Topically Injectable

List any known allergies you have had to any medications, foods or environment:

1) _____ **3)** _____

2) _____ **4)** _____

Do you suffer from seasonal allergies? ❑ Yes ❑ No **If Yes, have you had allergy testing before? ❑ Yes ❑ No**

Do you suffer from food sensitivity? ❑ Yes ❑ No **If Yes, have you had food sensitivity testing before? ❑ Yes ❑ No**

Health History: Please mark any condition you have now or had in the past

❑Weight Loss	❑Erectile Dysfunction	❑Easy Bruising	❑Heart Murmur	❑Heartburn	❑Lesions
❑Fatigue	❑Leaky Bladder	❑Easy Bleeding	❑Chest Pain	❑Nausea	❑Strength Loss
❑Fever	❑Blood in Urine	❑Hair Loss	❑Palpitations	❑Constipation	❑Memory Loss
❑Swollen Joints	❑Frequent Urination	❑Weight Gain	❑Short of Breath	❑Diarrhea	❑Headaches
❑Joint Pain	❑Painful urination	❑Coughing	❑Fainting	❑Abdominal Pain	Frequency_____
❑Stiffness	❑Chronic Sore Throat	❑Asthma	❑Swollen Ankles	❑Vertigo	❑Other_____
❑Muscle Pain	❑Difficult Hearing	❑Difficult Breathing	❑Pregnant	❑Sinus Trouble	_____
❑Anxiety	❑Depression	❑Tremors	❑Numbness	❑Ear Ringing	_____

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. Please state (P) for Patient or (F) for family**

❑ Alcoholism	**(P or F)**	❑ High Blood Pressure	**(P or F)**	❑ Stroke	**(P or F)**
❑ Anemia	**(P or F)**	❑ Kidney Disease	**(P or F)**	❑ Suicide Attempt	**(P or F)**
❑ Asthma	**(P or F)**	❑ Liver Disease	**(P or F)**	❑ Thyroid Disease	**(P or F)**
❑ Cancer/Tumor	**(P or F)**	❑ Hepatitis	**(P or F)**	❑ Heart Disease	**(P or F)**
❑ Diabetes	**(P or F)**	❑ Lung Disease	**(P or F)**	❑ Ulcers	**(P or F)**
❑ Drug Abuse	**(P or F)**	❑ Rheumatic Arthritis	**(P or F)**	❑ HIV or Other Immune Disease	**(P or F)**
❑ Depression	**(P or F)**	❑ Osteoarthritis	**(P or F)**	❑ High Cholesterol	**(P or F)**
❑ Epilepsy/Seizures	**(P or F)**	❑ Osteoporosis	**(P or F)**	❑ Rash/ Itching	**(P or F)**
❑ Abnormal Pap	**(P or F)**	❑ Eye Problems	**(P or F)**	❑ Abnormal Mammo	**(P or F)**
❑ Other _____					

Patient Signature: _____ Date: _____ Dr Initials _____

1st Chief Complaint: _____

When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint :_____

When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____

When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show <u>where</u> you are experiencing <u>all</u> of your current complaints:

Do you have pain and/or difficulty performing any of the following activities?

- ❑ Personal Care
- ❑ Lifting
- ❑ Reading
- ❑ Concentrating
- ❑ Work
- ❑ Driving
- ❑ Sleeping
- ❑ Recreation
- ❑ Walking
- ❑ Sitting
- ❑ Standing
- ❑ Social Life

A: Ache

B: Burning

C: Cramping

D: Dull Pain

F: Stiffness

N: Numbness

R: Throbbing

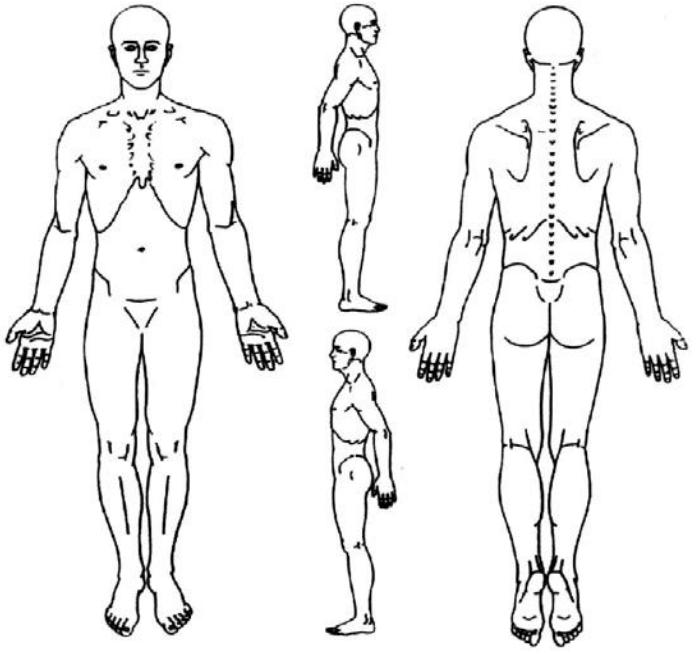
S: Soreness

T: Tingling

X: Sharp Pain

SP: Shooting Pain

RP: Radiating Pain



Have you ever had tests for your present condition? ❑MRI ❑X-ray ❑ CT ❑Other _____

Do you have a pacemaker? ❑Yes ❑No

Do you drink alcohol? ❑ Yes ❑No If Yes, what is frequency _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ No ❑ Former smoker If yes, how often do you smoke? _____

When was your last Physical examination? _____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Surgeries? ❑ Yes ❑No If yes, list:_____

_____

_____

Trauma History: Please list any traumas you have had throughout your life, even back to childhood. Include athletic injuries, auto accidents, and falls: _____

_____

_____