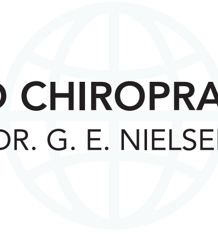
505 Aber Drive
Waterford, WI 53185



WATERFORD CHIROPRACTIC OFFICE

DR. G. E. NIELSEN

(262) 534-3767
docnielsen@aol.com

New Patient Information Worksheet

Name: ________________________________ **SS#:** __________________ **Age:** ________

Address: ____

City: __________________________ **State:** ______ **Zip:** ____________

Home Phone: ________________ **Cell Phone:** _______________ **Birth Date:** ____________

Employed By: ____________________________ **Spouse Name:** ________________________

Spouse's Birth Date: ____________________ **Spouse's SS#:** __________________________

Your E-mail Address: ____

Referred By: (Friend) (Relative) (Website) (Newspaper Ad) (Yellow Pages) (Sign) (Other) ____________

Which one of our patients should we thank for referring you? ________________________

Please circle your current chief complaint(s) and/or symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain) (Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain) (Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other) ____

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past five years: ____

____

Have you ever had spinal surgery? (No) (Yes) ______________________________________

List any serious condition the doctor should be aware of: __________________________

____

Previous Chiropractor: ______________________________ **Were you satisfied?** (No) (Yes)

***Females: Are you pregnant at this time?** (No) (Yes) **Due Date:** ____________________

Office Policies: *If I am accepted as a patient at the Waterford Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent To Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Nielsen to proceed with any necessary treatment. I have read Dr. Nielsen's office policies and consent to treat information, and I agree with them by signing below:*

Signature: ____ **Date:** ________________

Parent/Guardian's Signature: ____________________________ **Date:** ________________

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Activities Of Daily Living (ADL) Worksheet

Patient's Name:____**Date:**________________

Please circle the number which most closely describes your "Activities Of Daily Living" today.

1. Pain Intensity

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency Of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain *25% of the day*	Intermittent Pain *50% of the day*	Frequent Pain *75% of the day*	Constant Pain *100% of the day*

3. Personal Care (Washing, Dressing, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain *No restrictions*	Mild Pain *No restrictions*	Moderate Pain *Need to go slowly*	Moderate Pain *Need some assistance*	Severe Pain *Need 100% Assistance*

4. Travel (Driving, Riding, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain *On long trips*	Mild Pain *On long trips*	Moderate Pain *On long trips*	Moderate Pain *On short trips*	Severe Pain *On short trips*

5. Work

(0)	(1)	(2)	(3)	(4)
Can do usual work *Plus extra work*	Can do usual work *No extra work*	Can do 50% *Of usual work*	Can do 25% *Of usual work*	Cannot Work

6. Recreational Activities

(0)	(1)	(2)	(3)	(4)
Can do all	Can do most	Can do some	Can do a few	Cannot do any

7. Sleep Disturbance

(0)	(1)	(2)	(3)	(4)
None	Mild	Moderate	Severe	Completely

8. Lifting

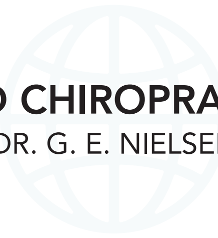
(0)	(1)	(2)	(3)	(4)
No pain *With heavy weight*	Increased pain *With heavy weight*	Increased pain *With moderate weight*	Increased pain *With light weight*	Increased pain *Any weight*

9. Walking

(0)	(1)	(2)	(3)	(4)
No pain *Any distance*	Increased pain *After one mile*	Increased pain *After half mile*	Increased pain *After quarter mile*	Increased pain *With any walking*

10. Standing

(0)	(1)	(2)	(3)	(4)
No pain *After several hours*	Increased pain *After several hours*	Increased pain *After one hour*	Increased pain *After half hour*	Increased pain *With any standing*



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Patient Health History Worksheet

Patient's Name:____**Date:**________________

Significant Past Health History

Have you ever been hospitalized?

a) No

b) Yes: (Year:_______) (Reason:_________________)

Have you had any surgeries?

a) No

b) Yes: (Year:_______) (Reason:_________________)

Do you have any significant health problems?

a) No

b) Yes: (___________________________________)

Significant Past Medical History

Have you seen another doctor for this condition?

a) No

b) Yes: (Name:_____________________________)

Did this doctor recommend any treatment?

a) No

b) Yes: (___________________________________)

Are you taking any medications?

a) No

b) Yes: (___________________________________)

Significant Past Social History

Do you play any sports or exercise?

a) No

b) Yes: (___________________________________)

How many hours do you sleep a night? (________)

How many hours a week do you work? (________)

Significant Family Medical History

Did your father have any health problems?

a) No

b) Yes: (___________________________________)

Did your mother have any health problems?

a) No

b) Yes: (___________________________________)

Did your brother(s) have any health problems?

a) No

b) Yes: (___________________________________)

Did your sister(s) have any health problems?

a) No

b) Yes: (___________________________________)

Did either of your grandmothers have any health problems?

a) No

b) Yes: (___________________________________)

Did either of your grandfathers have any health problems?

a) No

b) Yes: (___________________________________)

Health Risk Factors

Do you drink alcohol?

a) No

b) Yes: (___________________________________)

Do you smoke?

a) No

b) Yes: (___________________________________)

Anything else the doctor should know about?

a) No

b) Yes: (___________________________________)

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Patient Health History Worksheet

Patient's Name:____**Date:**________________

Present Health History

When did your present condition begin?
a) Gradual Onset (no specific date)
b) Date:______________________________

What caused your present condition?
a) No specific injury
b) Home accident
c) Work Accident
d) Auto Accident

What happened to cause your present pain?
____
____
____
____
____

Have you ever had these symptoms before?
a) No
b) Yes: (Date:______________________________)

What time of day are your symptoms **better**?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are your symptoms **worse**?
a) Morning
b) Afternoon
c) Evening
d) All of the above (constant pain)

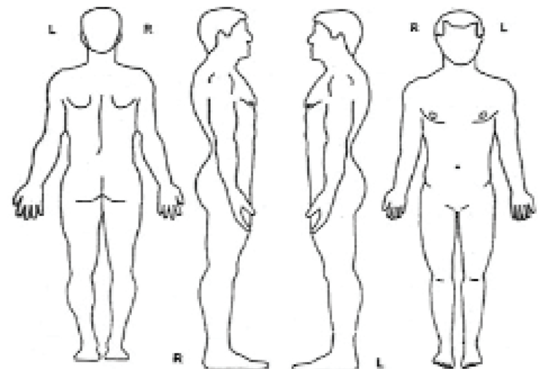
Have you missed any work from this condition?
a) No
b) Yes: (Date:______________________________)

What makes your pain **better**?
a) Rest
b) Ice packs/Heating pads
c) Prescription Medications
d) Drug store medications (Ibuprofen, Advil)
e) Other: ______________________________

What makes your pain **worse**?
a) Activity (work, repetitive motions)
b) Ice packs/Heating pads
c) Driving (or riding) in car
d) Other: ______________________________

What home remedies have you tried?
a) Ice packs
b) Heating pads/Hot tubs
c) Exercise
d) Other: ______________________________

Please Label The Area(s) Of Today's Pain
(Sharp, Dull, Radiating, Aching, Burning, Numbness)



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