Health in Motion Chiropractic and Rehabilitation

2185 East 53rd Street, Davenport, Iowa 52807 Telephone (563) 355-0081

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Can Dr. Rausch use your email address to contact you concerning your care, newsletters and promotions? Y/N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer ☐ Newspaper

☐ Referral: _____ ☐ Other: _____

Name of:

MD/DO/PA: _____

DC/PT: _____

Emergency Contact:

Name:_____ Relationship:_____ Telephone:_____

Are you currently under the care of another physician? Y/N

Physicians Name:_____ Telephone:_____

For what condition?_____

Treatment?_____

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

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FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

Childhood Illnesses:

- ☐ ADHD ☐ atopic dermatitis ☐ allergies ☐ anemia
- ☐ Asthma ☐ bedwetting ☐ cerebral palsy ☐ chicken pox
- ☐ Crohn's ☐ depression ☐ diabetes ☐ ear infections
- ☐ Headaches ☐ hepatitis ☐ HIV ☐ measles
- ☐ Mumps ☐ psoriasis ☐ rash ☐ scoliosis
- ☐ Seizures ☐ sickle cell ☐ spina bifida ☐ other

Vaccinations: ☐ I have been fully vaccinated ☐ I get the flu shot regularly ☐ I have had some vaccines
☐ I haven't been vaccinated ☐ I have had travel vaccines (ie. Hepatitis) ☐ I don't know/don't remember

Adult Illnesses:

- ☐ ADD ☐ Alzheimer's ☐ arthritis ☐ asthma
- ☐ Cancer ☐ cerebral palsy ☐ chicken pox ☐ colitis
- ☐ CRPS(RSD) ☐ CVA(stroke) ☐ cystic kidney disease ☐ depression
- ☐ Diabetes ☐ eczema ☐ emphysema ☐ eye problems
- ☐ Fibromyalgia ☐ high blood pressure ☐ hepatitis ☐ HIV
- ☐ Heart disease ☐ influenza pneumonia ☐ liver disease ☐ lung disease
- ☐ Lupus ☐ multiple sclerosis ☐ Parkinson's ☐ pneumonia

☐ Psoriasis ☐ psychiatric condition ☐ scoliosis ☐ seizures

☐ Shingles ☐ STD's ☐ suicide attempts ☐ thyroid problems

☐ Vertigo ☐ Osteoporosis ☐ other:_____

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Year: _____ Description: _____

Major mental/emotional traumas: (loss of loved one, divorce, career change, miscarriage, major disease, etc.)

_____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

_____

Please list supplements you are currently taking:

1. _____ (Brand) (Supplement Name) (Daily Dose)
2. _____ (Brand) (Supplement Name) (Daily Dose)
3. _____ (Brand) (Supplement Name) (Daily Dose)
4. _____ (Brand) (Supplement Name) (Daily Dose)
5. _____ (Brand) (Supplement Name) (Daily Dose)
6. _____ (Brand) (Supplement Name) (Daily Dose)
7. _____ (Brand) (Supplement Name) (Daily Dose)
8. _____ (Brand) (Supplement Name) (Daily Dose)

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Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

____ Alcohol
____ Artificial sweeteners
____ Candy or other sweets
____ Pop/soda
____ Chewing tobacco
____ Cigarettes
____ Cigars/pipes
8. _____ Coffee
9. _____ Fast food
10. _____ Fried foods
11. _____ Luncheon meats/hot dogs
12. _____ Margarine
13. _____ Milk/cheese/yogurt, etc.
14. _____ Non-herbal tea
15. _____ Refined flour/baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, tap
20. _____ Water, well
21. _____ Diet often (Y or N)

LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)
_____Sleep 7-9 hours/night (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin/Ibuprofen
_____ Asthma inhalers
_____ Beta blockers
_____ Birth control
_____ Chemotherapy
_____ Cortisone
_____ Diabetic medications
_____ Diuretics
_____ Heart medications
_____ High blood pressure
_____ Hormone Therapy
_____ Laxatives
_____ Insulin
_____ Recreational drugs
_____ Relaxants/Sleeping pills
_____ Thyroid medication
_____ Tylenol/acetaminophen
_____ Ulcer medications
OOther: _____

REVIEW OF SYSTEMS

Please put a check mark by all that apply:

Constitutional

__None __Chills __daytime drowsiness __fatigue
__Fever __loss of appetite __night sweats __weight gain/loss

Eyes/Vision

__None __blindness __blind spots __cataracts
__double vision __itchy eyes __photophobia __eye tearing

Ears/Nose/Throat

__None __dizziness __ear discharge __ear pain
__fainting __sore throats __headaches __hearing loss
__head injury __loss of smell __nosebleeds __nasal congestion
__runny nose __sinus infection

Respiration

__None __asthma __cough __cough up blood
__short of breath __produce sputum __wheezing

Cardiovascular

__None __claudication __heart problem __heart murmur
__high bp __low bp __orthopnea __palpitations
__ulcers __varicose veins __shortness of breath __difficulty breathing lying down

Gastrointestinal

__None __abdominal pain __abnormal stool __belching
__black/tarry stool __constipation __diarrhea __difficulty swallowing
__heartburn __hemorrhoids __indigestion __jaundice
__ulcers __rectal bleeding __loss of bowl control

Female

__None/NA __abnormal bleeding __breast lump __cramps
__breast pain __burning urination __frequent urination __hormone therapy
__irregular menses __vaginal discharge __urine retention __urine incontinence

I am currently pregnant__ I am not currently pregnant__

Age of first menses____ Age when menopause began____ Date of last menstrual period_____

Number of complicated pregnancies____ Number of uncomplicated pregnancies____ Number of C-sections___

Number of vaginal deliveries___ Number of miscarriages___ Number of terminated pregnancies___

Male

__None __erectile dysfunction __burning urination __hesitancy/dribbling
__frequent urination __urine retention __urine incontinence __prostate problems

Skin

__None __change in skin color __change in nail texture __hair loss
__hives __skin disorders __itching __numbness
__rash __skin lesions/ulcers __varicosities

Nervous System

__None __dizziness __facial weakness __headache
__limb weakness __loss of memory __loss of consciousness __numbness
__seizures __sleep disturbance __slurred speech __stress
__stroke __loss of balance __unsteady gait

Psychological

__None __anxiety __behavioral change __bi-polar disorder
__confusion __convulsions __depression __insomnia
__loss of appetite __memory loss __mood change

Hematologic

__None __anemia __bleeding __blood clotting
__blood transfusion __bruise easily __fatigue __lymph node swelling

Do you crave certain foods? Y/N _____

Do you have energy crashes? Y/N Time/s: _____

Employer?Job?_____

Hobbies? Sports? Activities?_____

Signature_____ Date_____