Health in Motion Chiropractic and Rehabilitation

2185 East 53rd Street, Davenport, Iowa 52807 Telephone (563) 723-1288

PATIENT INFORMATION

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

Address: _____

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

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

Can Dr. Ringelstetter use your email address to contact you concerning your care? 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 ☐ 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: _____

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Read the following questions and circle the number that applies:

0 (leave blank) = Do not experience
1 = Minor or mild symptom, or it rarely occurs (once a month or less)
2 = Moderate symptom or it occasionally occurs (weekly)
3 = Severe symptom or it frequently occurs (daily or almost daily)

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 __birth control __breast lump
__breast pain __burning urination __frequent urination __hormone therapy
__irregular menses __vaginal discharge __urine retention __urine incontinence
__cramps

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/NA __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

Height: _____ Weight: _____ Do you have a religious/spiritual practice? Y/N _____

Blood Type (if known): _____ Do you crave certain foods? Y/N _____

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

Employer?Job?_____

Hobbies? Sports? Activities?_____

Successful health care and preventive medicine are only possible when I have a complete understanding of you – including your expectations and obstacles to cure. The nature of your responses to the following questions will go a long way in assisting how I can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What do you know about the chiropractic approach?

2. What expectations do you have from **this** visit to our clinic?

3. What **long term** expectations do you have from working with our clinic?

4. What expectations do you have **of me personally** as your health care provider?

5. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:

   0% 1 2 3 4 5 6 7 8 9 10 (100%)

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **self-destructive?**

8. What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?

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All of the answers I have provided are accurate to the best of my knowledge and I agree to continue with my Chiropractic evaluation with Health in Motion Chiropractic and Rehabilitation at this time.

Patient Signature:_____ Date:_____