STOIBER HEALTHCARE, S.C.
CONFIDENTIAL PATIENT INFORMATION FORM

Full Name:_____Phone: (____)_____Date:____/____/____

Address:_____
(City) (State) (Zip Code)

Employer: _____ Cell phone: (____)_____

E-Mail Address: _____

Age:_____ Date Of Birth:_____/_____/_____ SS:_____# of Children:_____

Marital Status: Married Single Widow/Widower Divorced (Please circle one)

Race: Asian Black Caucasian Hispanic Native American Prefer not to answer (Please circle one)

Ethnicity: Non-Hispanic Hispanic Prefer not to answer (Please circle one)

Name of spouse or legal guardian:_____

Billing address: _____Home phone:(_____)_____

Spouse or legal guardian employer: _____**Work phone:(_____)_____**

Who may we thank for referring you to us?_____ May we use your name to send this person a thank you from the doctors? _____ yes _____ no
How did you hear about us? _____ Word of mouth _____ Phone book _____ Newspaper Ad
_____ Radio _____ Website _____Other

INSURANCE INFORMATION

Our office will copy your insurance card(s). We will gladly bill your insurance(s) for you IF we have all the proper information. Please inform us of your insurance(s) now and if there are any future changes.

Primary Insurance Co: _____ Name of Insured:_____ DOB_____

Secondary Insurance Co: _____ Name of Insured:_____ DOB_____

Supplemental Insurance Co:_____ Name of Insured:_____ DOB_____
*Supplemental Ins. applies only to Medicare patients

Your payment today will be made by CASH _____by CHECK _____ by CREDIT CARD:_____

****SIGNATURE of patient or legal guardian:** _____Date:_____

PLEASE READ: By signing above, I clearly understand the conditions of my personal insurance policy as it affects chiropractic coverage and agree that ALL services rendered me are charged directly to me and that I AM PERSONALLY RESPONSIBLE FOR PAYMENT of all charges incurred. I further authorize payment of medical benefits to Stoiber Healthcare, S.C.

If this is an **AUTOMOBILE accident or WORK related: Complete the following:**

Date of accident:_____ Time:_____am/pm Location:_____

How did the accident occur? On the job Auto collision Other

If not Auto, then please describe:_____

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev. 4/19/99

Patient Name_____ ***Date***_____

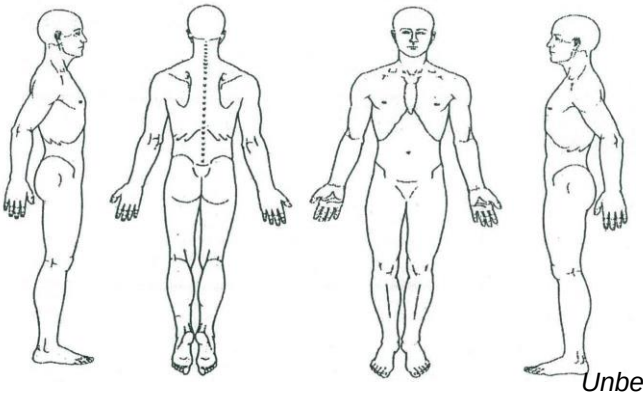
1. When did your symptoms start:_____ ***Describe your symptoms and how they began***:

_____

_____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

(1) Constantly (76 -100% of the day)
(2) Frequently (51-75% of the day)
(3)Occasionally (26-50% of the day)
(4)Intermittently (0-25% of the day



3. What describes the nature of your symptoms?

(1) Sharp (4) Shooting
(2) Dull ache (5) Burning
(3) Numb (6) Tingling

4. How are your symptoms changing?

(1) Getting better
(2) Not changing
(3) Getting worse

5. How bad are your symptoms at their: *None* *Unbearable*

a. worst: *(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)*
b. best: *(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)*

6. How do your symptoms affect your ability to perform daily activities?

(0)	*(1)*	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse:

*☐Nothing ☐Lying down ☐Walking ☐Standing ☐Sitting ☐Movement or exercise ☐Inactivity ☐ Other*_____

8. What activities make your symptoms better:

*☐Nothing ☐Lying down ☐Walking ☐Standing ☐Sitting ☐Movement or exercise ☐Inactivity ☐ Other*_____

9. Who have you seen for your symptoms? *(1) No one (3) Medical doctor (5) Other*
(2) Other chiropractor (4) Physical therapist

When and what treatment? _____
What tests have you had for your symptoms and when were they performed? *(1) X-rays date:*_____ *(3) CT scan date:* _____ *(2) MRI date:*_____ *(4) Other date:*_____

10. Have you had similar symptoms in the past? *(1) Yes (2) No*

a. If you have received treatment in the past for the same of similar symptoms, who did you see? *(1) This office (3) Medical doctor (5) Other (2) Other chiropractor (4) Physical Therapist*

11. What is your occupation? *(1) Professional/executive (4) Laborer (7) Retired*
(2) White collar/secretarial (5) Homemaker (8) Other
(3) Tradesperson (6) FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status? *(1) Full-time (3) Self-employed (5) Off work (2) Part-time (4) Unemployed (6) Other*

12. What do you hope to get from your visit/treatment (select all that apply):

(1) Reduce symptoms (3) Explanation of condition/treatment (5) How to prevent this from occurring again
(2) Resume/increase activity (4) Learn how to take care of this on my own (6)

*Patient Signature*_____ *Date*_____