SPENNETTA FAMILY CARE CHIROPRACTIC, 6810 Watts Rd Madison WI 53719

NAME_____ DATE_____

Have you changed your address in the last 6 months? If so, please list new address and phone number.

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

Present Complaint:_____

_____

When did this problem begin; specific date if possible?_____(most recent onset)

Did this problem begin: ( )Immediately after a specific incident ( )Uneventfully ( )Gradually developed over time

If this problem began after a specific incident, PLEASE EXPLAIN:_____

_____

Is complaint a result of Auto Accident? Work Related?_____

Have you seen anyone else for this condition? ( )Yes ( )No. If yes by: ( )Chiropractor ( )MD ( )Therapist ( )Other (SPECIFY DATES & TYPE OF TREATMENT)_____

_____

Describe current pain (YOU MAY CHECK ONE OR MORE ANSWERS): ( )Sharp/Stabbing ( )Dull ( ) Soreness ( )Weakness ( )Throbbing/Gnawing ( )Numbness ( )Shooting ( )Gripping/Confining

How often are the complaints present? ( )Constant, _____hours per day, _____days per week, _____days per month.

If you were to describe the intensity of the pain would you say its: ( )Mild/Dull ( )Moderate ( )Severe/Excruciating/Agonizing

Since your problem began is the pain: ( ) Increasing ( ) Decreasing ( ) Not changing

Indicate how your symptoms are affected by physical activity:

( )Symptoms are unaffected by rest, exercise, etc.

( )Symptoms increase with, or are made worse by, exercise or physical activity.

( )Symptoms increase with, or are made worse by, rest or inactivity.

Are your complaints affecting your ability to work or otherwise be active?

( )No effect ( )Need assistance often.

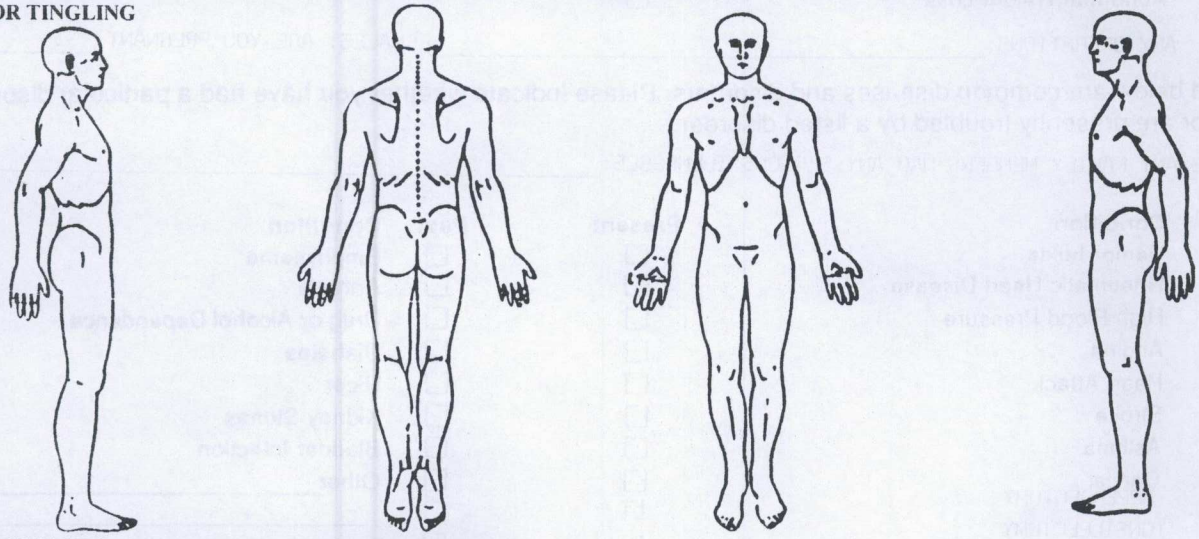
( )Some physical restrictions (able to perform light duty work and household tasks).

( )Need limited assistance with common everyday tasks.

( )Have a significant inability to function without assistance.

( )Am totally disabled (Impaired). Cannot care for self.

MARK AN X ON THE PICTURE WHERE YOU HAVE HAD PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



NEW PATIENTS COMPLETE OTHER SIDE

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you have ever *had* a listed symptom in the *past*, please check that symptom in the *left hand column*. If you are *presently* troubled by a particular symptom, check that symptom in the *right hand column*.

Past	Musculoskeletal	Present
☐	Neck Pain	☐
☐	Shoulder Pain	☐
☐	Pain in Upper Arm or Elbow	☐
☐	Hand Pain	☐
☐	Upper Back Pain	☐
☐	Low Back Pain	☐
☐	Pain in Upper Leg or Hip	☐
☐	Pain in Lower Leg or Knee	☐
☐	Pain in Ankle or Foot	☐
☐	Jaw Pain	☐
☐	Swelling of Joints (Specify Joints)	☐
	_____	
☐	Stiffness of Joints (Specify Joints)	☐
	_____	

Past	Nervous System	Present
☐	Depression	☐
☐	Insomnia	☐
☐	Bed Wetting	☐
☐	Fainting	☐
☐	Convulsions	☐
☐	Dizziness	☐
☐	Headache	☐
☐	Muscular Incoordination	☐
☐	Hearing Loss	☐
☐	Tinnitus (Ear Noises)	☐
☐	Ear Pain	☐
☐	Impaired Vision	☐
☐	Eye Pain	☐

Past	Cardiovascular	Present
☐	Rapid Heart Beat	☐
☐	Chest Pains	☐

Past	Endocrine	Present
☐	Loss of Appetite	☐
☐	Abnormal Weight Gain	☐
☐	Abnormal Weight Loss	☐

Past	Respiratory	Present
☐	Shortness of Breath	☐
☐	Chronic Pain	☐
☐	Chronic Cough	☐
☐	Chronic Sinusitis	☐

Past	Gynecologic	Present
☐	Pain Durning Menstruation	☐
☐	Irregular Menstrual Flow	☐
☐	Spotting	☐
☐	Menopausal Symptoms	☐

LAST MENSTRAL PERIOD, DATE: _____
DO YOU USE CONTRACEPTIVE DEVICES _____

Past	Genito-Urinary	Present
☐	Painful Urination	☐
☐	Loss of Bladder Control	☐
☐	Frequent Urination	☐
☐	Urethral Discharge	☐

Past	GI Tract	Present
☐	Abdominal Pain	☐
☐	Difficulty in Swallowing	☐
☐	Heartburn/Indigestion	☐
☐	Constipation	☐

Past	Skin	Present
☐	Rash	☐
☐	Dermatitis or Eczema	☐
☐	Persistent Itching	☐

Please check any of the following that apply to you.

☐	Tobacco	☐
☐	Alcohol	☐
☐	Tranquilizers/Sedatives	☐
☐	Laxatives	☐
☐	Other _____	☐
	_____	
	_____	
☐	Coffee, cups per day_____	☐

ANY OPERATIONS: _____ FEMALES: ARE YOU PREGNANT: _____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

HAVE ANY FAMILY MEMBERS HAD ANY SERIOUS ILLNESSES: _____

Past	Condition	Present
☐	Hemorrhoids	☐
☐	Rheumatic Heart Disease	☐
☐	High Blood Pressure	☐
☐	Angina	☐
☐	Heart Attack	☐
☐	Stroke	☐
☐	Asthma	☐
☐	Cancer	☐
☐	APPENDECTOMY	☐
☐	TONSILLECTOMY	☐
☐	HERNIA	☐

Past	Condition	Present
☐	Emphysema	☐
☐	Arthritis	☐
☐	Drug or Alcohol Dependence	☐
☐	Diabetes	☐
☐	Ulcer	☐
☐	Kidney Stones	☐
☐	Bladder Infection	☐
☐	Other_____	☐
☐	_____	☐
☐	_____	☐

Past	Nervous System	Present
( )	Depression / **Deprecion**	( )
( )	Insomnia / **Insomnio**	( )
( )	Bed Wetting / **Moja la cama**	( )
( )	Fainting / **Desmayos**	( )
( )	Convulsions / **Convulsiones**	( )
( )	Dizziness / **Mareos**	( )
( )	Fainting / **Desmayos**	( )
( )	Convulsions / **Convulciones**	( )
( )	Dizziness / **Mareos**	( )
( )	Headache / **Dolor de Cabeza**	( )
	Muscular In coordination	
( )	**Incordinacion Muscular**	( )
	Hearing Loss	
( )	**Perdida de la Audicion**	( )
	Tinnitus (Ear Noises)	
( )	**Sumbidos (sonido en los oidos)**	( )
( )	Ear Pain / **Dolor de Oidos**	( )
( )	Impaired Vision / **Vista Borrosa**	( )
( )	Eye Pain / **Dolor en el ojo**	( )

Past	GENITO-URINARY	Present
( )	Painfill Urination/ **Dolor al Orinar**	( )
( )	Loss of Bladder Control/**Perdida control de vejiga**	( )
( )	Frequent Urination / **Orinacion Frecuente**	( )
( )	Urethral Discharge / **Descarga de la Uretra**	( )

Past	GI Tract	Present
( )	Abdominal Pain / **Dolor Abdominal**	( )
( )	Difficulty in Swallowing/**Dificultad al tragar**	( )
( )	Heartburn/Indigestion /**Agrugras o Indigestion**	( )
( )	Constipation / **Estrenimiento**	( )

Past	SKIN	Present
( )	Rash / **Picason**	( )
	Dermatitis or Eczema	)
( )	**Dermatitis o Eczema**	( )
( )	Persistin Itching / **Picason Persistente**	( )

Past	Cardiovascular	Present
( )	Rapid Heart Beat / **Palpitacion rapida**	( )
( )	Chest Pains / **Dolor en el Pecho**	( )

Past	Endocrine	Present
( )	Loss of Appetite / **Perdida de Apetito**	( )
	Abnormal Weight Gain	
( )	**Aumento de peso anormal**	( )
	Abnormal Weight Loss	
( )	**Perdida de peso anormal**	( )

Past	Please check any that apply to you **Por favor marque a lo que aplican**	Present
( )	Tobacco / **Tabaco**	( )
( )	Tranquilizers/Sedatives / **Tranquuilizantes / Sedantes**	( )
( )	Laxatives / **Laxantes**	( )
( )	Other / **Otro**_____	( )
	Coffee, cups per day	
( )	**Tazas de café por dia**_____	( )

Any operation /**Alguna Operacion:**_____

Females: Are you Pregnant /**Esta Embarazada:**_____

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently t
a listed disorder.
En la lista siguiente esta una serie de desordenes y enfermedades comues. Por favor indique si ha tenido alguno en el pasado o en el prese
problemas o desordenes listados a continuacion.

HAVE ANY FAMILYMEMBERS HAD ANY SERIOUS ILLNESSES:_____
Algun miembro de su familia a tenido alguna seria enfermedad.

Condition	Present	Past
	Hemorrhoids / **Emorroides**	( )
	Rheumatic Heart Disease	
( )	**Desorden Reumatico de Corazon**	( )
( )	High Blood Pressure / **Presion Alta**	( )
( )	Angina / **Ataques o Convulsiones**	( )
( )	Heart Attack / **Ataque Cardiaco**	( )
( )	Stroke / **Embolias**	( )
( )	Asthma / **Asma**	( )
( )	Cancer / **Cancer**	( )
( )	Appendectomy / **Apendicitis**	( )
( )	Tonsillectomy / **Amigdalitis**	( )
( )	Hernia / **Ernias**	( )

Condition	Present	Past
	Emphysema / **Efisema**	( )
	Arthritis / **Artritis**	( )
	Drug or Alcohol Dependence	
( )	**Dependencia de Drogas o Alcohol**	( )
( )	Diabetes / **Diabetis**	( )
( )	Kidney Stone / **Piedras en los Rinones**	( )
( )	Bladder Infection / **Infeccion en la Vejiga**	( )

Other / Otro_____
_____
_____