BEAVER DAM CHIROPRACTIC CLINIC S.C.

DR. WILLIAM LENTSCHER & DR. JAKE LENTSCHER
250 Corporate Drive • Beaver Dam, Wisconsin 53916 • (920) 887-7156 • www.BDChiro.com

Confidential Patient Health Record Date _____

Name _____ Home Phone _____

Street _____ City _____ Zip Code _____

Age _____ Birth Date _____

Marital Status: Single ____ Married ____ Widow(er) ____ Divorced ____ How Many Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone _____

Patient's Nearest Relative _____ Phone _____

Name of Primary Insurance Company _____ Other Ins_____

Present Family Doctor _____ Address _____

Date of Last Physical Examination _____ By Doctor _____

Referred by _____

List Present Complaints

1. _____ For How Long _____

2. _____ For How Long _____

3. _____ For How Long _____

4. _____ For How Long _____

Remarks: _____

_____

_____

List Other Doctors Consulted for this Condition

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

What Surgery Have You Had?

Type _____ When _____Doctor _____

Type _____ When _____Doctor _____

Type _____ When _____Doctor _____

Type _____ When _____Doctor _____

Type _____ When _____Doctor _____

Remarks _____

_____

List Serious Accidents and Falls:

What _____ When _____

What _____ When _____

What _____ When _____

Remarks _____

_____

List Fractures:

What _____ When _____

What _____ When _____

Remarks _____

_____

List Medications and/or Diet Supplements You Take:

What _____ Frequency_____ Doctor _____

What _____ Frequency_____ Doctor _____

What _____ Frequency_____ Doctor _____

What _____ Frequency_____ Doctor _____

Remarks _____

_____

Check any of the following that you have or have had:

Appendicitus	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Disease
Diphtheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Attack	Epilipsy
Pneumonia	Measles	Goiter	Mental Disorder
Rheumatic Fever	Mumps	Influence	Lumbago
Polio	Small Pox	Pleurisy	Eczema

Check any of the following you have or have had in the past five years:

General Symptoms
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of Sleep
Fatigue
Nervousness
Loss of Weight
Numbness or pain in arms, hands or legs
Allergy
Neuralgia

Eyes, ears, nose and throat
Failing Vision
Near Sightedness
Crossed Eyes
Eye Pain
Deafness
Ear Noises
Ear Discharge
Nose Bleeds
Nasal Obstruction
Sore Throat
Hoarseness
Hay Fever
Asthma
Dental Decay
Enlarged Thyroid
Tonsillitis
Sinus Infection
Enlarged glands
Heart Disease
Cancer

Skin
Skin Eruptions
Itching
Bruises Easily
Dryness
Boils
Varicose Veins
Sensitive Skin
Hives or Allergy

Respiratory
Chronic Cough
Spitting up Phlegm
Spitting up Blood
Chest Pain
Difficult Breathing

Cardio-vascular
Rapid Beating Heart
Slow beating heart
High Blood Pressure
Low Blood Pressure
Pain Over Heart
Previous Heart Stroke
Hardening of Arteries
Swelling of Ankles
Poor Circulation
Paralytic Stroke

Muscle and Joint
Stiff Neck
Back Ache
Swollen Joints
Tremors
Painful Tail Bone
Foot Trouble
Pain between Shoulders
Hernia
Spinal Curvature
Faulty Posture

Genitourinary
Frequent Urination
Painful Urination
Blood in Urine
Pus in Urine
Kidney Infection or Stones
Bed Wetting
Inability to Control Urine
Prostate Trouble

Gastrointestinal
Poor Appetite
Excessive hunger
Belching or Gas
Nausea
Vomiting
Vomiting of Blood
Pain over Stomach
Distention of Abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (Piles)
Intestinal Worms
Liver Trouble
Gall Bladder Trouble
Jaundice
Colitis

Female
Painful Menstrual Periods
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Back Ache
Previous Miscarriage
Vaginal Discharge
Congested Breast
Lumps in Breast
Menopausal Symptoms

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipts. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that id I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ SS # _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.