BEAVER DAM CHIROPRACTIC & REHAB

DR. JAKE LENTSCHER · DR. JOSH LENTSCHER · DR. PAIGE PINNOW

250 Corporate Drive • Beaver Dam, Wisconsin 53916 • (920) 887-7156

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 _____
5. _____ For how long _____

Remarks: _____

_____

_____

_____

_____

List other doctors consulted for this condition(s):

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

Name _____ Address _____

Diagnosis _____ Results _____

See other side

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 diseases you have or have had:

Appendicitis
Scarlet fever
Diphtheria
Typhoid fever
Pneumonia
Rheumatic fever
Polio
Malaria
Tuberculosis
Whooping cough
Anemia
Measles
Mumps
Small pox
Chicken pox
Diabetes
Cancer
Heart Attack
Goiter
Influenza
Pleurisy
Alcoholism
Venereal infection
Arthritis
Epilepsy
Mental disorder
Lumbago
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
Earache
Ear noises
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
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 perssure
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 receipt. 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 if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ S S # _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

Please return this completed form to the receptionist.