



STOIBER CHIROPRACTIC

710 East Grand Avenue
Wisconsin Rapids, WI 54494
(p) 715-424-8000 (f) 715-424-8020

Patrick G. Stoiber, DC

Patient Information

Name: _____
(Last) (First) (MI)

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

Phone: _____ Optional Phone: _____

Employer: _____

Age: _____ Gender: _____ Date Of Birth: _____ Social Security #: _____
(For insurance purposes only)

Referred by: _____

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

Billing Address if different from above: _____

Policy Holder _____ **DOB (of policy holder)** _____

Email Address: _____

Insurance Information:

Our office is willing to process all insurance claims. We will gladly submit to your insurance **IF** we are given the proper insurance information. Please have us copy your insurance cards and keep us informed and up-to-date with any changes. It is the patient's responsibility to be knowledgeable of their insurance benefits. If you have any questions, you can call the customer service number on the back of your insurance card.

If you have any questions concerning your monthly statement you can call us at 715-424-8000 and ask for the patient accounts department.

I understand that Stoiber Chiropractic will bill my insurance on my behalf. I also understand that any services/supplies/supplements my insurance does not cover, are my sole responsibility.

_____ **Date:** _____

Patient/Guardian Signature (Please indicate relationship to patient)

Patient Health Questionnaire

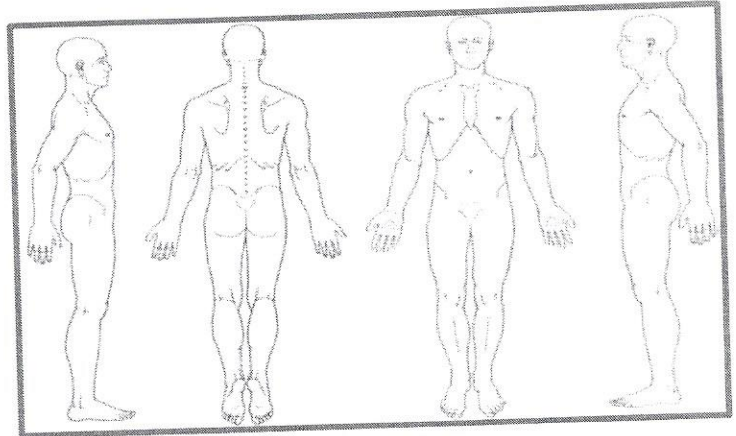
Patient Name: _____ Date: _____

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

2. How often do you experience your symptoms?

- a) Constantly (76-100% of the day)
- b) Frequently (51-75% of the day)
- c) Occasionally (26-50% of the day)
- d) Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- Sharp
- Dull Ache
- Numb
- Shooting
- Burning
- Tingling

4. How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

5. How bad are your symptoms at their:

None Unbearable
Worst: 0 1 2 3 4 5 6 7 8 9 10
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 Moderate, interferes Limiting, prevents Intense, preoccupied Severe, no activity
With activity with activity full activity with seeking relief possible

7. What activities make your symptoms worse? _____

8. What activities make your symptoms better? _____

9. Who have you seen for your symptoms?

- a) No one b) Other Chiropractor c) Medical Doctor d) Physical Therapist e) Other _____

When and what treatment? _____

What tests have you had for your symptoms and when were they performed?

- a) Xrays _____ b) MRI _____ c) CT Scan _____ d) Other _____

10. Have you had similar symptoms in the past? Yes _____ No _____

Who did you see? This office Other Chiropractor Medical Doctor Physical Therapist Other _____

11. What is your occupation? _____

12. What do you hope to get from your visit/treatment? Circle all that apply.

- Reduce symptoms
- Explanation of condition/treatment
- Resume/increase activity
- Learn how to take care of this on my own
- How to prevent this from occurring again

Patient Signature: _____

Smoking Status (circle one): Current Everyday Smoker Occasional Smoker Past Smoker Never Smoker

List all known allergies: _____

What type of regular exercise do you perform (circle one)? None Light Moderate Strenuous

What is your height and weight? _____ ft _____ in _____ lbs

What is your blood pressure (if known): _____ / _____

For each of the conditions listed below, please check if you have had the condition in the past or present.

Past	Present		Past	Present		Past	Present	
<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Excessive Thirst
<input type="radio"/>	<input type="radio"/>	Upper Back Pain	<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	Frequent Urination
<input type="radio"/>	<input type="radio"/>	Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Blood in Urine
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Dependence
<input type="radio"/>	<input type="radio"/>	Shoulder Pain	<input type="radio"/>	<input type="radio"/>	Kidney Disorders	<input type="radio"/>	<input type="radio"/>	Allergies
<input type="radio"/>	<input type="radio"/>	Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Wrist Pain	<input type="radio"/>	<input type="radio"/>	Painful Urination	<input type="radio"/>	<input type="radio"/>	Systemic Lupus
<input type="radio"/>	<input type="radio"/>	Hand Pain	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control	<input type="radio"/>	<input type="radio"/>	Epilepsy
<input type="radio"/>	<input type="radio"/>	Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	Prostate Problems	<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema/Rash
<input type="radio"/>	<input type="radio"/>	Knee/Lower Leg Pain	<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
<input type="radio"/>	<input type="radio"/>	Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/>	Loss of Appetite	<input type="radio"/>	<input type="radio"/>	Females Only:
<input type="radio"/>	<input type="radio"/>	Jaw Pain	<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Birth Control Pills
<input type="radio"/>	<input type="radio"/>	Joint Stiffness/Swelling	<input type="radio"/>	<input type="radio"/>	Ulcer	<input type="radio"/>	<input type="radio"/>	Hormonal Replacement
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Pregnancy
<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	Liver/Gallbladder Disorder	Other Health Problems/Issues (please list)		
<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Cancer	❖ Circle if an immediate family member has had any of the following: Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus High Blood Pressure		
<input type="radio"/>	<input type="radio"/>	Muscular Incoordination	<input type="radio"/>	<input type="radio"/>	Tumor			
<input type="radio"/>	<input type="radio"/>	Visual Disturbances	<input type="radio"/>	<input type="radio"/>	Asthma			
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis			
<input type="radio"/>	<input type="radio"/>	Numbness	<input type="radio"/>	<input type="radio"/>	Ringing in Ears			

Current Medications: (if you have a list please ask us to make a photo copy)

_____ mg	_____ mg	_____ mg
_____ mg	_____ mg	_____ mg

List all Surgical Procedures/Broken Bones/Fractures/Child Birth:

_____ yr	_____ yr	_____ yr
_____ yr	_____ yr	_____ yr

Do you use any of the following (circle)? If so, please indicate how much/often.

Caffeine Tobacco Alcohol

Date: _____

Patient Signature: _____