



STOIBER CHIROPRACTIC

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Wisconsin Rapids, WI 54494
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Patrick G. Stoiber, DC

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Patient Information

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

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

Phone: _____ Optional Phone: _____

Employer: _____

Age: _____ Gender: _____ Pronouns (optional): _____

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

Referred by: _____

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

Parent or Guardian : _____

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 Name: _____ **Date:** _____

PATIENT HEALTH QUESTIONNAIRE

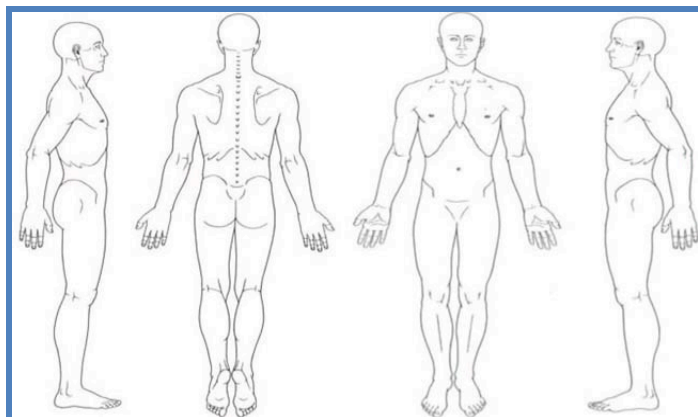
IS THIS A WORK RELATED/AUTO INJURY? YES _____ NO _____

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 you 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 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? _____

8. What activities make your symptoms better? _____

9. Who is your primary medical doctor? _____

10. Who have you seen for your symptoms?

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

11. When and what treatment? _____

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

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

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

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

14. What is your occupation? _____

15. 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: _____

