# STOIBER CHIROPRACTIC

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Victoria Zueger, 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)

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.

*The relationship of Patrick Stoiber Chiropractic S.C. and Dr. Victoria Zueger is an office sharing relationship. Dr. Zueger practices as an independent business entity and is neither an employee nor owner of Patrick Stoiber Chiropractic S.C. Each healthcare provider maintains their own separate records and maintains separate responsibility for providing healthcare services.*

**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)**

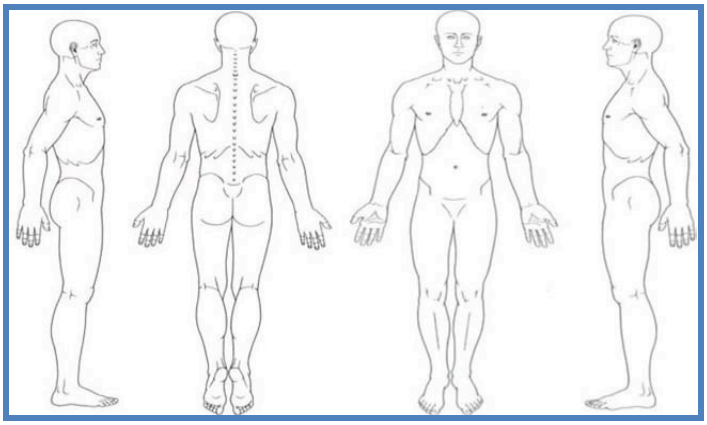
## PATIENT HEALTH QUESTIONNAIRE

**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 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: _____

## Patient Health Questionnaire Cont.

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

**Current Medications: (if you have a list of medications, 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**

**Patient Signature:** _____ **Date:** _____