TWIN PORTS WELLNESS + AESTHETICS

1728 Tower Ave, Superior, WI 54880 Phone: 715.395.0928 Fax: 715.395.0930

Twin Ports Clinic of Chiropractic ~ Comprehensive Health History Form

Patient Information

Patient Name: _____
(last) (first) (middle initial)

Address: _____

City: _____ State: _____ ZIP:_____

Cell Phone: (____)_____

Home Phone: (____)_____

Work Phone: (____)_____

Email: _____

Best Contact: Cell Phone Work Phone Email

DOB: _____ Age: _____ Sex: M or F

Status: Married Widowed Single Other: _____

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____

Relationship: _____Phone: (____)_____

How Did You Hear About Us?

Referral: _____ Internet

Direct Mail Seminar Other: _____

Primary Care

Primary Care Physician's Name: _____
Clinic Name: _____
Phone: _____
I allow my health progression to be shared with my primary care physician?
Yes No
Do you have current X-rays at another office or clinic? Yes or No

Accident Information

Do you currently have an active accident claim? Y or N Date:_____
Type of Accident: Auto Work Home Other: _____
To whom have you made a report of your accident?
Auto Insurance Employer Work Comp Other: _____
Claim # _____
Adjuster: _____Adjuster Phone: _____
Address: _____

Insurance Information

Who is responsible for this account? Self
Other: _____

If other, what is the relationship to patient:
_____

Insurance Company: _____

Treatment Disclaimer

Before Receiving Consultation or Treatment In Our Office Please Review These Principles Outlined Below:

1. Dr. Hoefflings goal is to provide you with adjunctive and supportive care for your health condition. We do not claim to treat or cure any disease or medical diagnosis.

2. Our office offers some services that are not covered by insurance. These services are considered experimental and may not be billed to your insurance. Dr. Hoeffling will review all services that are considered covered services and those that are not. Nutritional support may be offered for your case. Nutritional supplements are not FDA regulated and have not been proven to cure or treat any disease or illness.

3. Our services are not a replacement for your medical treatment. We choose to work alongside your medical provider as this serves you in the most effective manner possible.

4. Dr. Hoeffling will never give advice on the use of your medications. Medications must be managed by your medical doctor. You must work with a medical doctor for the management of any medications you take now or in the future.

5. I completely understand that there are no guarantees of help, correction, relief, or cure, written, spoken or implied. I understand that this clinic does NOT treat any disease or any medical diagnosis.

6. I am making a sane and conscious decision to seek advice as per the above understood terms for either myself and/or my dependents. In doing so, I agree to the above terms and acknowledge this with my signature below:

Patient Signature: _____

Date:_____

Patient Name: _____ Date: _____

TWIN PORTS WELLNESS + AESTHETICS

1728 Tower Ave, Superior, WI 54880 Phone: 715.395.0928 Fax: 715.395.0930

Twin Ports Clinic of Chiropractic ~ Comprehensive Health History Form

Current Medications

Medication **Dosage** **Condition**

_____
_____
_____
_____
_____
_____

Have your medications or supplements ever caused you unusal side effects or problems? ☐ Yes ☐ No Describe: _____

_____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Apsirin? ☐ Yes or ☐ No

Tylenol? ☐ Yes ☐ No

Blood Thinner/Anticoagulant? ☐ Yes ☐ No

Steriods Present or Past? ☐ Yes ☐ No

Medication Allergies: _____

Reaction? _____

Supplement Allergies: _____

Reaction? _____

Food Allergies: _____

Reaction? _____

Do you have any surgical devices in your body? (ie screws, pins, plates, etc.)

☐ Yes ☐ No ☐ If yes, where located:_____

_____

Current Supplements

Supplement **Dosage** **Condition**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Condition

What specific condition prompted you to choose us for your healthcare needs?

_____
_____

When did the condition(s) begin?

_____
_____

Has it occurred before? ☐ Yes ☐ No When? _____

Is the condition getting worse? ☐ Yes ☐ No ☐ Unknown

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury ☐ Slip/Fall

☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other: _____

Rate the severity of your pain 1 (least) to 10 (severe)

1 2 3 4 5 6 7 8 9 10

How often do you have this pain? ☐ Constant ☐ Frequent ☐ Occasional

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services

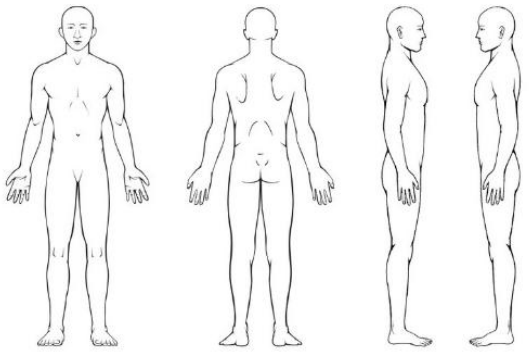
☐ None ☐ Other:

_____

Please list Current and Ongoing Problems in Order of Severity:

Problem: _____
☐ Mild ☐ Moderate ☐ Severe
Treatment/Approach: _____
Success: ☐ Excellent ☐ Good ☐ Fair ☐ No change
Problem: _____
☐ Mild ☐ Moderate ☐ Severe
Treatment/Approach: _____
Success: ☐ Excellent ☐ Good ☐ Fair ☐ No change

Label the Diagram Below for CURRENT Areas of Discomfort:



A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins & Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Patient Name: _____ Date: _____

TWIN PORTS WELLNESS + AESTHETICS

1728 Tower Ave, Superior, WI 54880 Phone: 715.395.0928 Fax: 715.395.0930

Twin Ports Clinic of Chiropractic ~ Comprehensive Health History Form

General Pain Index Questionnaire

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities. Use the following guide: **0 = Completely able to & 10 = Totally Unable to Function**

1. Family/At-Home Responsibilities (ex. Yard work, chores/housework, etc.)
   0 1 2 3 4 5 6 7 8 9 10
2. Recreation including hobbies, sports, or other leisure activities
   0 1 2 3 4 5 6 7 8 9 10
3. Social Activities including parties, theater, concerts, dining-out etc.
   0 1 2 3 4 5 6 7 8 9 10
4. Employment including volunteer work and homemaking tasks
   0 1 2 3 4 5 6 7 8 9 10
5. Self-care such as taking a shower, driving, or getting dressed
   0 1 2 3 4 5 6 7 8 9 10
6. Life- support activities such as eating and sleeping
   0 1 2 3 4 5 6 7 8 9 10

SCORE_____ (60)

Lifestyle History

Check Your Exercise/Activity Levels:

☐ Inactive ☐ Light ☐ Moderate ☐ Heavy ☐ Vigorous

Please check all that apply:

☐ Tobacco – Type _____ Amt/Day: _____
Are you exposed to 2nd hand smoke regularly? ☐ Yes ☐ No
☐ Alcohol Drinks/Week: _____
☐ Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have previously used recreational drugs? ☐ Yes ☐ No
If yes, what types/method (IV, inhaled, smoked, etc.) _____
_____

Work Activity

Labor Activity

☐ Light ☐ Moderate ☐ Heavy ☐ Sedentary

Work Activity Level

☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Student ☐ Unemployed

Hours per week: _____ **Mostly** ☐ Sitting ☐ Walking ☐ Standing

Daily Activities

Activity of daily living most affected?

☐ Employment ☐ Personal Care ☐ Sleeping ☐ Social Life

Activities difficult to perform?

☐ Bending Over ☐ Caring for Family ☐ Climbing Stairs ☐ Concentrating
☐ Dressing Self ☐ Driving Car ☐ Exercising ☐ Getting in/out of car
☐ Getting to sleep ☐ Grocery Shopping ☐ Performing Household Chores
☐ Lifting Objects ☐ Looking over shoulder ☐ Lying Down
☐ Reaching overhead ☐ Rising out of chair/bed ☐ Showering/bathing
☐ Sitting ☐ Standing ☐ Staying Asleep ☐ Using a computer ☐ Walking
☐ Yard Work

Health History

Please check all that apply (past or present)/ circle **CURRENT** Conditions

☐ Allergies ☐ Alcohol/Drug Abuse ☐ Anemia ☐ Anxiety
☐ Appendicitis ☐ Arthritis ☐ Asthma ☐ Bleeding Disorders
☐ Blood Clot ☐ Blood Transfusion ☐ Breast Lump ☐ Cancer
☐ Cerebral Palsy ☐ Chest Pain ☐ COPD ☐ Crohn's/Colitis
☐ Depression ☐ Diabetes (insulin) ☐ Diabeties (non-insulin)
☐ Fibromyalgia ☐ Fractures ☐ Gallstones ☐ Gout ☐ Headaches
☐ Heart Attack ☐ Heart Disease ☐ Heart Failure ☐ Hernia
☐ Herniated Disk ☐ High Blood Pressure ☐ High Cholesterol
☐ Hypertension ☐ Hypoglycemic ☐ Kidney Stones ☐ Liver Disease
☐ Migraine Headaches ☐ Multiple Sclerosis ☐ Osteoporosis
☐ Pacemaker ☐ Pinched Nerve ☐ Renal (kidney) Failure
☐ Rheumatoid Arthritis ☐ Scoliosis ☐ Seizure Disorder
☐ Sickle Cell Anemia ☐ Sleep Apnea ☐ Stroke (CVA)
☐ Thyroid Problems ☐ Tumors, Growths ☐ None

Other: _____

Patient Name: _____ Date: _____

TWIN PORTS WELLNESS + AESTHETICS

1728 Tower Ave, Superior, WI 54880 Phone: 715.395.0928 Fax: 715.395.0930

Twin Ports Clinic of Chiropractic ~ Comprehensive Health History Form

Review of Symptoms

Indicate which of the below you have experienced in the **last 1-2 months.**
1= Never 2= Rarely 3= Occasionally 4= Frequently 5= Constantly

Muscular/Skeletal

Ankle/Foot Pain 1 2 3 4 5
Arthritis 1 2 3 4 5
Balance Problems 1 2 3 4 5
Elbow Pain 1 2 3 4 5
Fibromyalgia 1 2 3 4 5
Hip Pain 1 2 3 4 5
Joint Pain 1 2 3 4 5
Knee Pain 1 2 3 4 5
Low Back Pain 1 2 3 4 5
Muscles Aches 1 2 3 4 5
Muscle Cramping 1 2 3 4 5
Muscle Stiffness (am) 1 2 3 4 5
Neck Pain 1 2 3 4 5
Pain Between Shoulder 1 2 3 4 5
Pain Wakens You 1 2 3 4 5
Shoulder Pain 1 2 3 4 5
Weakness in Arms/Legs 1 2 3 4 5
Wrist/Hand Pain 1 2 3 4 5

Hematologic

Anemia 1 2 3 4 5
Ease of Bleeding 1 2 3 4 5
Blood Clotting 1 2 3 4 5
Blood Transfusion 1 2 3 4 5
Bruise Easily 1 2 3 4 5

Neurological

Burning 1 2 3 4 5
Facial/Limb Weakness 1 2 3 4 5
Numbness 1 2 3 4 5
Tingling 1 2 3 4 5

Surgical History

Please check all the apply/ Indicate when and any comments/results

Surgeries (Indicate Year)

__ None
__ Appendectomy _____
__ Cardiac Bypass _____
__ Carpal Tunnel _____
__ C-Section _____
__ Cosmetic _____
__ Gall Bladder _____
__ Hysterectomy _____
__ Joint Replacement _____
__ Knee _____
__ Spinal Fusion _____
__ Other _____

Injuries

__ Back Injury _____
__ Broken Bones/Fractures _____
__ Head Injury _____
__ Industrial _____
__ Neck Injury _____
__ Severe Fall _____
__ Soft Tissue _____
__ Other _____

Family History

Please check all the apply ■ **Adopted** (Family History Unknown)

Condition	**Mother**	**Father**	**Brother**	**Sister**	**Children**
Alcohol/Drug Abuse	_____	_____	_____	____	____
Anemia	_____	_____	_____	____	____
Anxiety	_____	_____	_____	____	____
Arthritis	_____	_____	_____	____	____
Asthma	_____	_____	_____	____	____
Autoimmune Disease	_____	_____	_____	____	____
Cancer: _____	_____	_____	_____	____	____
Depression	_____	_____	_____	____	____
Diabetes	_____	_____	_____	____	____
Disc Problems	_____	_____	_____	____	____
Epilepsy	_____	_____	_____	____	____
Heart Disease	_____	_____	_____	____	____
High Blood Pressure	_____	_____	_____	____	____
High Cholesterol	_____	_____	_____	____	____
Insomnia	_____	_____	_____	____	____
Kidney Trouble	_____	_____	_____	____	____
Liver Trouble	_____	_____	_____	____	____
Obesity	_____	_____	_____	____	____
Migraine Headaches	_____	_____	_____	____	____
Scoliosis	_____	_____	_____	____	____
Stomach Troubles	_____	_____	_____	____	____
Stroke	_____	_____	_____	____	____
Thyroid Disorder	_____	_____	_____	____	____
Other:	_____	_____	_____	____	____

If any of the above family members are deceased, please list their age at death and cause: _____

_____
_____
_____

Patient Name: _____ Date: _____

1728 Tower Ave, Superior, WI 54880 Phone: 715.395.0928 Fax: 715.395.0930

Twin Ports Clinic of Chiropractic ~ Comprehensive Health History Form

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment; therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Twin Ports Clinic of Chiropractic uses trained staff to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instructions, etc. Occasionally, when your chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE – Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 per 10 million treatments. The most recent studies (journal of the CCA, Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

SORENESS – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your Doctor of Chiropractic if you experience soreness or discomfort.

SOFT TISSUE INJURY – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or soft tissue injury.

RIB INJURY – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatments are preformed carefully to minimize such risk.

PHYSICAL THERAPY BURNS – Heat generated by physical therapy modalities may cause miner burns to the skin. While these are rare, they should be reported to your Doctor of Chiropractic or staff if they occur.

OTHER PROBLEMS – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

I, the undersigned, hereby authorize the doctor of Twin Ports Clinic of Chiropractic and assistants to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of any medical information necessary to process my insurance claim(s) and that payment be made directly to Twin Ports Clinic of Chiropractic. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

If you have any questions concerning the above, please ask your Doctor of Chiropractic. When you have full understanding and consent to have care provided, please print and sign your name and date below.

PATIENT'S NAME PRINTED

_____

TODAY'S DATE

_____

PATIENT SIGNATURE

_____

PARENT/GUARDIAN FOR MINOR

_____

1728 Tower Ave, Superior, WI 54880 Phone: 715.395.0928 Fax: 715.395.0930

Twin Ports Clinic of Chiropractic ~ Comprehensive Health History Form

Initial Uses Authorization Form

Effective 10/2004

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Twin Ports Clinic of Chiropractic. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. James Hoeffling.

Twin Ports Clinic of Chiropractic also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial to give authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact: Dr. James Hoeffling.

You can reach the Privacy Official at: Twin Ports Clinic of Chiropractic, 1728 Tower Ave, Superior, WI 54880 or call 715-395-0928 during hours available. A message may be left for our privacy official any time at the clinic is open and your call will be returned within 7 business days.

Your email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature of Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

Staff complete only if NO signature is obtained, if it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

- ☐ Patient refused to sign this acknowledgment even though the patient was asked to do so, and the patient was given Notice Privacy Practices
- ☐ Other: _____

Staff Signature: _____ Date: _____