Green Bay Chiropractic Clinic
Dr. Maureen O'Connor
515 S. Military Avenue
Green Bay, WI 54303
Phone: (920) 490-0200 **Fax:** (920) 490-9698

PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #:
City:	Sex: Male Female
State: Zip:	Marital Status:
Home Phone:	Race: Ethnicity:
Cell Phone:	Language Spoken:
Email Address:	Emergency Contact:
Employer:	Emergency Phone:
Work Phone:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address:	Social Security #:
City:	Employer:
State: Zip:	Employer Address:
Home Phone:	Employer City:
Work Phone:	Employer State:
Cell Phone:	Zip:

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Member #:	Member #:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Deductible:	Deductible:
Subscriber Name:	Subscriber Name:

ADDITIONAL INFORMATION (*If applicable*)

Attorney Name:	Adjuster Name:
Phone:	Phone:
Address:	Fax:

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to the Physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

Signature:_____ Date:_____

Name: Date:

Reason for visit: *(circle all that apply)*

Back pain Neck pain Mid-back pain
RT arm pain RT leg pain LT arm pain LT leg pain

Your pain has been as high as:

(none) 0 1 2 3 4 5 6 7 8 9 10 *(severe)*

Date of Injury: _____

If no injury, how long have you had your pain?

_____ Days Weeks Months Years *(circle one)*

The pain is: *(circle all that apply)*

Continuous Occasional

When is your pain worse? *(circle all that apply)*

Morning Daytime Evening Night time

Describe your pain: *(circle all that apply)*

Dull Sharp Aching Knifelike Stabbing Throbbing
Shooting Burning Like pins and needles

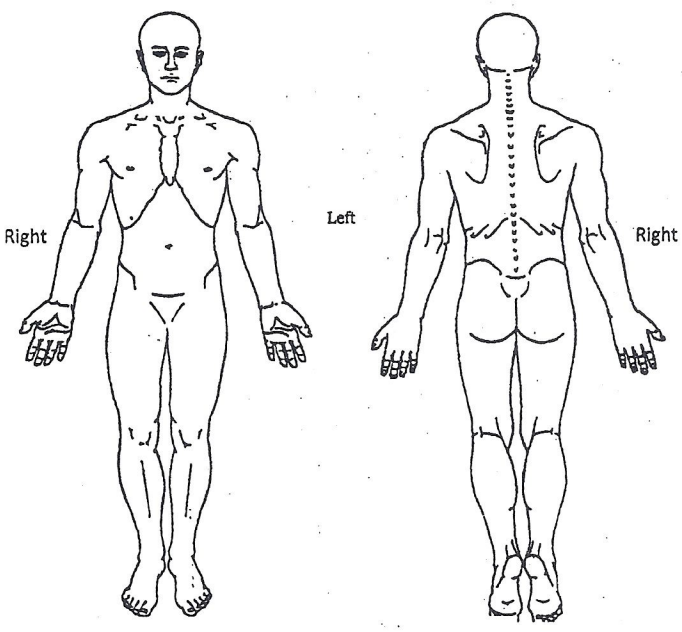
What makes your pain worse? *(circle all that apply)*

Lifting Bending Laying Sitting Standing Driving
Changes in weather Walking Coughing Sneezing

What makes your pain better? *(circle all that apply)*

Medications Bending Laying Sitting Standing
Walking Changing positions Nothing

Mark the location of your pain:



What associated symptoms do you have? *(circle all that apply)*

Numbness Weakness Catching Giving out

Do you have any recent changes in controlling your bowels or bladder? *(circle one)*

Yes No

Do you have any unexplained fevers above 101.5°F? *(circle one)*

Yes No

Do you have any unexplained weight loss greater than 15 pounds? *(circle one)*

Yes No

What treatments have you had for this problem? *(circle all that apply)*

Medication Physical therapy Chiropractic Care Surgery
Epidural Steroid Injections Facet Injections Joint Injections
Trigger Point Injections Acupuncture Nothing

What diagnostic studies have you had for this problem? *(circle all that apply)*

X-ray MRI CT Scan Myelogram Discogram
Bone Scan Bone Density Scan EMG Nothing

If symptoms are due to an injury, what type of injury did you have? *(circle all that apply)*

Work related Traffic accident Lifting injury Fall injury
Object fell on you Repetitive use injury

Review of Systems: **Do you currently have any of the following medical symptoms?** *(check all that apply)*

Symptom	Yes	No
Weight Gain		
Advanced Care Plan		
Rash		
Visual Disturbances		
Cough		
Shortness of Breath		
Chest Pain		
Cough		
Cold Hands/Feet		
Swelling in Legs		
Constipation		
Incontinence of Bowel		
Nausea		
Incontinence of Bladder		
Muscle Weakness		
Balance Problems		
Seizures		
Sleep Disturbance		
Depression		
Appetite Changes		
Abnormal Bleeding		

Allergies:

(Please list all medication allergies, and the type of reaction to the medication, including allergies to iodine, contrast dye, & shellfish.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History / Family History:

Have you ever been diagnosed with: ***(circle answer)***

High Blood Pressure: Yes No

Diabetes: Yes No

If you answered "Yes" to either question, please indicate what Medications, if any, you are currently prescribed

Illness *(check all that apply)*	**You**	**Any Family Member**
Cancer		
Heart Disease		
High Blood Fats/Cholesterol		
Vein trouble/Blood Clots		
Stroke/TIA		
Asthma		
Sleep Apnea		
Lung Disease		
Esophageal Reflux/Stomach Ulcers		
Liver Disease/Hepatitis		
Kidney/Bladder Disease		
Abnormalities of Female Organs		
Abnormalities of Prostate		
Thyroid Disease		
Abnormal Bleeding		
Blood Problems(Anemia, High/Low White count)		
Joint Disease		
Anxiety/Depression/Psychiatric Illness		
History of Substance Addiction		
Skin Disease		
Other:_____		

Surgical History: ***(circle all that apply)***

Cosmetic	Bowel	Vascular
Cancer	Lung	Kidney/Bladder
Head/Brain	Appendix	Liver/Gall Bladder
Cataract	Hernia	Prostate/Female Organs
Tonsils	Bone/Joint	Sinus/Nose
Heart	Spine	Other: _____

Social History: Who lives with you? ***(circle all that apply)***

Self Spouse Family Children Child Parent(s)
Roommate Significant Other Partner Friend Caregiver
Group Home Other: _____ Pet(s):_____

Tobacco use: Current Smoker Past Smoker
Never Smoked Chew/ Dip

If so, how often:_____

Alcohol use: Yes No

If so, how often:_____

Illegal Drug use: Yes No

What is your occupation?

_____

Are you currently working? ***(circle one)*** Yes No

Medications:

(Please list ALL of your current medications, including over-the-counter medications. Please list dosages and how often you take the medication.)

NAME	DOSE	FREQUENCY

Pregnancy History: ***(circle one; for women only)***

Are you currently pregnant? Yes No Unknown

Please provide any other concerns or comments:

_____

_____

_____

For Office Use Only:

F/U: _____ days/weeks/months

Inj:_____

MRI:_____

EMG/NCS:_____

PT:_____

X-Ray:_____

Referral to:_____

Dictation#:_____

E&M Code:_____

ICD-9 Code:_____

Weight: _____ lbs. Height: _____ in.

BP: Systolic:_____ Diastolic: _____ BPM: _____