

WELLNESS CHIROPRACTIC

Dr. Brian J. Thalhamer, DC

635 Fifth Street, Santa Rosa, Calif. 95404

(707) 575-8988 · fax (707) 575-5704

Name _____ Address _____

City _____ State _____ Zip _____ Home ph _____ Cell ph _____

Pager _____ e-mail home _____ e-mail work _____

SSN _____ Date of Birth _____ Age _____ Name of Spouse/Parent _____

Male Female Single Married Divorced # of children _____

How were you referred to our office? (circle) Friend Relative Newspaper ad Sign/Walk by Other _____

Which one of our patients should we thank for referring you? _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work ph _____ Occupation _____

Please check your current symptoms:

- Headaches Neck Pain Neck Stiffness Allergies Shoulder/Arm Pain Upper Back Pain Mid-Back Pain
 Low-Back Pain Hip/Pelvis Pain Sinus Problems Asthma Stomach Pain Chest Pain
 Numbness Arthritis Sciatica Other: _____

My symptoms are due to: (circle) Auto Accident Work Accident Sport Accident Other Accident Gradual Onset

Please list any surgeries you have ever had: _____

Have you ever had spinal surgery? If so, when? _____

List any serious health conditions the doctor should be aware of: _____

Previous Chiropractor: _____ Date of last visit: _____ Were you satisfied? Y N

** Females ** Are you pregnant at this time? Y N Due Date: _____

OFFICE POLICIES: *If I am accepted as a patient at Wellness Chiropractic I agree to pay for all services including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

CONSENT TO TREAT: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Thalhamer to proceed with any necessary treatment. I have read Dr. Thalhamer's office policies and consent to treatment information, and I agree with them by signing below.*

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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Patient Name: _____ Date _____

Please circle the number which most closely describes your "Activities of Daily Living" today.

1. Pain Intensity

0 ----- 1 ----- 2 ----- 3 ----- 4
 No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

2. Pain Frequency

0 ----- 1 ----- 2 ----- 3 ----- 4
 No Pain Occasional Pain Intermittent Pain Frequent Pain Constant Pain
 25% of the day 50% of the day 75% of the day 100% of the day

3. Personal Care

0 ----- 1 ----- 2 ----- 3 ----- 4
 No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain
 No Restrictions No Restrictitons Need to go slowly Need some help Need 100% assistance

4. Travel (Driving, riding, etc.)

0 ----- 1 ----- 2 ----- 3 ----- 4
 No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
 On long trips On long trips On long trips On short trips On short trips

5. Work

0 ----- 1 ----- 2 ----- 3 ----- 4
 Can do usual work Can do usual work Can do 50% Can do 25% Cannot work
 and extra work No extra work of usual work of usual work

6. Recreation

0 ----- 1 ----- 2 ----- 3 ----- 4
 Can do all Can do most Can do some Can do a few Cannot do any
 activities activities activities activities activities

7. Sleeping

0 ----- 1 ----- 2 ----- 3 ----- 4
 Perfect sleep Mildly disturbed Moderately disturbed Greatly disturbed Totally disturbed

8. Lifting

0 ----- 1 ----- 2 ----- 3 ----- 4
 No pain with Increased pain Increased pain Increased pain Increased pain
 heavy lifting with heavy lifting with moderate lifting with light weight with any weight

9. Walking

0 ----- 1 ----- 2 ----- 3 ----- 4
 No pain Increased pain Increased pain Increased pain Increased pain
 any distance after 1 mile ½ - 1 mile ¼ - ½ mile with all walking

10. Standing

0 ----- 1 ----- 2 ----- 3 ----- 4
 No pain Increased pain Increased pain Increased pain Increased pain
 after several hours after several hours after 1 hour after ½ hour with all standing

11. Sitting

0 ----- 1 ----- 2 ----- 3 ----- 4
 No pain Increased pain Increased pain Increased pain Increased pain
 after several hours after several hours after 1 hour after ½ hour with all sitting

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PATIENT HEALTH HISTORY WORKSHEET

Patient Name: _____ Date _____

Significant Past Health History

Have you ever been hospitalized?

- a) NO
- b) YES (Year: _____, Reason: _____)

Have you ever had any surgeries?

- c) NO
- d) YES (Year: _____, Reason: _____)

Do you have any significant health problems?

- e) NO
- f) YES (_____)

Significant Past Medical History

Have you ever seen another doctor for this condition?

- g) NO
- h) YES (Name: _____)

Did this doctor recommend any treatment?

- i) NO
- j) YES (_____)

Are you taking any medications?

- k) NO
- l) YES (_____)

Significant Past Social History

Do you play any sports or exercise?

- m) NO
- n) YES (_____)

How many hours do you sleep each night? (____)

How many hours each week do you work? (____)

Significant Family Medical History

Did your father have any health problems?

- a) NO
- b) YES (_____)

Did your mother have any health problems?

- c) NO
- d) YES (_____)

Did your brother(s) have any health problems?

- e) NO
- f) YES (_____)

Did your sister(s) have any health problems?

- g) NO
- h) YES (_____)

Did your grandmother(s) have any health problems?

- i) NO
- j) YES (_____)

Did your grandfather(s) have any health problems?

- k) NO
- l) YES (_____)

Significant Health Risk Factors

Do you drink alcohol?

- a) NO
- b) YES (How much/day? _____)

Do you smoke?

- a) NO
- b) YES (What/how much? _____)

Is there anything else the doctor should know about?

- a) NO
- b) YES (_____)

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PATIENT HEALTH HISTORY WORKSHEET

Patient Name: _____ Date _____

Present Health History

When did your present condition begin?

- a) Gradual onset (no specific date)
- b) Date: _____

What caused your present condition?

- a) No specific injury
- b) Home accident
- c) Work accident
- d) Auto accident

What happened to cause your present pain/disfunction?

What time of the day are your symptoms better?

- a) Morning
- b) Afternoon
- c) Evening
- d) None of the above (constant pain)

What time of the day are your symptoms worse?

- e) Morning
- f) Afternoon
- g) Evening
- h) All of the above (constant pain)

What makes your pain better?

- a) Rest
- b) Ice packs
- c) Heating pads
- d) Over the counter medications (Advil, Tylenol)
- e) Prescriptions medications
- f) Other: _____

What makes your pain worse?

- a) Activity (work, repetitive motions)
- b) Ice packs
- c) Heating packs
- d) Driving/riding in a car
- e) Prolonged standing/sitting
- f) Bending/Lifting

What home remedies have you tried?

- a) Ice packs
- b) Heating pads
- c) Hot tub
- d) Exercise
- e) Other: _____

Have you missed any work from this condition?

- a) NO
- b) YES (Date: _____)

Have you ever had these symptoms before?

- a) NO
- b) YES (Date: _____)

Please Label The Area(s) of Today's Pain


