WOODLAKE CHIROPRACTIC

Dr. Paul Zilka
Dr. Ann Zilka

New Patient Information

Name _____

Today's date _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Birth date _____

Cell phone _____ Age _____

Gender _____ Number of children _____

Employer _____

Work address _____

Work phone _____

Type of work _____

Marital status _____

Social Security # _____

Email address _____

Would you like to receive our office newsletter and our monthly promotions by email? ☐ Yes ☐ No

Payment method for first visit: ☐ Cash ☐ Check ☐ Credit Card

Reason for this Visit

Current health complaints/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall
☐ Home injury ☐ Chronic discomfort ☐ Other

Please explain _____

If job related, have you made a report of your accident to your employer? Yes No

When did this condition begin? _____

Has this condition:
☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:
☐ Sleep ☐ Daily routine ☐ Other activities

Please explain _____

Has this condition occurred before? ☐ Yes ☐ No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

Emergency Contact / Spouse Info

Name _____

Employer _____

Work phone _____

Cell phone _____

General Questions

Do your mother, father, brother, sister, children have similar problems? ☐ Yes ☐ No

Do you have a history of cancer? ☐ Yes ☐ No

Do you have a history of corticosteroid use? ☐ Yes ☐ No

Have you experienced in the past, or do you now have, bowel and bladder problems? ☐ Yes ☐ No

Experience with Chiropractic

Who can we thank for referring you to this office? _____

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No Reason for those visits _____

Doctor's Name _____ Approximate date of last visit _____

Have any adults in your family seen a Chiropractor? ☐ Yes ☐ No

Have any children in your family seen a Chiropractor? ☐ Yes ☐ No

phone 612.866.9194 fax 612.866.9963 web www.woodlakechiro.com email woodlakechiro@yahoo.com

Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Relief care** — Symptomatic relief of pain or discomfort

☐ **Stabilization care** — Correcting and relieving the cause of the problem as well as the symptoms

☐ **Comprehensive care** — Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care, in combination with Massage Therapy and Nutrition.

☐ **I want the Doctor to select the type of care appropriate for my condition.**

Patient's signature _____ Date _____

Health Conditions

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or frequent headaches
☐ Sinus problems
☐ Dizziness
☐ Loss of sleep
☐ Pain between shoulders
☐ Frequent neck pain
☐ Numbness in arms/legs/hands
☐ Pain in arms/legs/hands
☐ Lower back problems
☐ Digestive problems
☐ Heart surgery/pacemaker
☐ Heart attack/stroke
☐ Heart murmur
☐ Congenital heart defect
☐ High/Low blood pressure
☐ Difficulty breathing
☐ Asthma
☐ Tuberculosis

☐ Alcohol/drug abuse
☐ Venereal disease
☐ HIV/AIDS
☐ Ulcers/Colitis
☐ Arthritis
☐ Diabetes
☐ Shingles
☐ Kidney problems
☐ Hepatitis
☐ Cancer
☐ Chemotherapy
☐ Rheumatic fever
☐ Psychiatric problems
☐ Thyroid problems
☐ Surgeries
☐ _____
☐ _____

For women:

Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking birth control? ☐ Yes ☐ No
Do you experience painful periods? ☐ Yes ☐ No
Do you have irregular cycles? ☐ Yes ☐ No
Do you have breast implants? ☐ Yes ☐ No

Health Habits

Do you smoke? ☐ Yes ☐ No
If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per day? _____

Do you drink caffeine? ☐ Yes ☐ No
If yes, how many cups per day? _____

How much water do you drink daily? _____ oz./day

Do you exercise regularly?
☐ Daily ☐ Moderate ☐ No

Do you wear:
☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Current Medications

☐ Muscle relaxers
☐ Insulin
☐ Blood pressure medicine
☐ Blood thinners
☐ Pain killers (including aspirin)
☐ Cholesterol medicine

Vitamins: _____
Supplements: _____
Other medications: _____
_____
_____

Authorization for Care

I hereby authorize the doctors of chiropractic in this office, including whomever they deem their assistants, to work with my condition through the use of adjustments and procedures the doctor deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's signature _____ Date _____
Guardian or spouse's signature authorizing care _____ Date _____

Who should receive bills for payment on your account?

_____Patient _____Spouse _____Parent _____Worker's Comp _____Auto Insurance _____Medicare _____Medicaid

Ownership of X-ray films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.