QUAD CITIES WELLNESS GROUP

2220 E. 53rd St ● Davenport, IA 52807 ● (O) : 563 - 355 - 3100 ● (F) : 888 - 534 - 6920

PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Date of birth : _____ / _____ / _____ Sex ☐ M ☐ F

Marital Status : ☐ M ☐ S ☐ W ☐ D

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

E-Mail: _____

Primary Care Physician: _____

Referring Physician: _____

EMERGENCY CONTACT INFORMATION

Name **Relationship** **Phone**

_____

RESPONSIBLE PARTY (If patient is un der 18 years of age)

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: _____

Phone: (_____)_____ Occupation: _____

INSURANCE INFORMATION

☐ I do not have health insurance

Insurance Company: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber's Date of birth : _____ / _____ / _____

Relationship to Subscriber : _____ Subscriber's Phone: (_____)_____ ☐ Home ☐ Cell ☐ Work

Is your visit a result of a motor vehicle / work accident? ☐ Yes ☐ No **(if yes, please inform the front desk)**

MEDICAL HISTORY (please check all that apply) ☐ None apply

☐ Heart attack	☐ Osteoporosis	☐ Gout	☐ Transplants
☐ Heart Failure	☐ Osteoarthritis	☐ Stomach Ulcer	☐ Phlebitis
☐ Heart Murmur	☐ Asthma	☐ Kidney Stones	☐ Blood clots in legs
☐ High Blood Pressure	☐ Pneumonia	☐ Kidney failure	☐ Blood clots in lungs
☐ Low Blood Pressure	☐ Tuberculosis	☐ Alcohol Dependence	☐ Insomnia
☐ High Cholesterol	☐ Emphysema	☐ Pacemaker	☐ GERD
☐ Rheumatoid arthritis	☐ Lung Disease	☐ HIV Positive / AIDS	☐ Loss of Memory
☐ Peripheral neuropathy	☐ Blood vessel Disease	☐ Hepatitis	☐ Cold Hands / Feet
☐ Peripheral vascular disease	☐ Mental Illness	☐ Lupus	☐ Hand Tremors
☐ Coronary artery disease	☐ Sleep apnea	☐ Liver Problems	☐ Epilepsy
☐ Bulging / Herniated disc	☐ ADHD / ADD	☐ Hyperthyroidism	☐ Stroke
☐ Spinal stenosis	☐ Gall Bladder Problems	☐ Hypothyroidism	☐ Diabetes
☐ *Cancer (please explain below)	☐ Other (please explain below)	☐ Hyperlipidemia	

* Explanation: _____

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or office and authorize the office to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance company.**

Patient Signature: _____ Date: _____ Account# :_____

QUAD CITIES WELLNESS GROUP

2220 E. 53rd St ● Davenport, IA 52807 ● (O) : 563 - 355 - 3100 ● (F) : 888 - 534 - 6920

HISTORY OF PRESENT PROBLEM

Chief complaint: (why are you seeing the doctor today): _____

How long have you had this problem: _____ Has the pain ever been a level 9 or 10? ☐ Yes ☐ No

When do you feel it most? ☐ AM ☐ PM ☐ All Day How long does the complaint last? _____ Mins _____ Hrs

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Does anything make your chief complaint worse? ☐ Yes ☐ No

If yes, please explain : _____

Does anything make your chief complaint better? ☐ Yes ☐ No

If yes, please explain : _____

Have you been treated previously for this condition? ☐ Yes ☐ No

Prior treatments for your chief complaint include: ☐ Chiropractic ☐ Physical Therapy ☐ Medical Doctor / Orthopedic

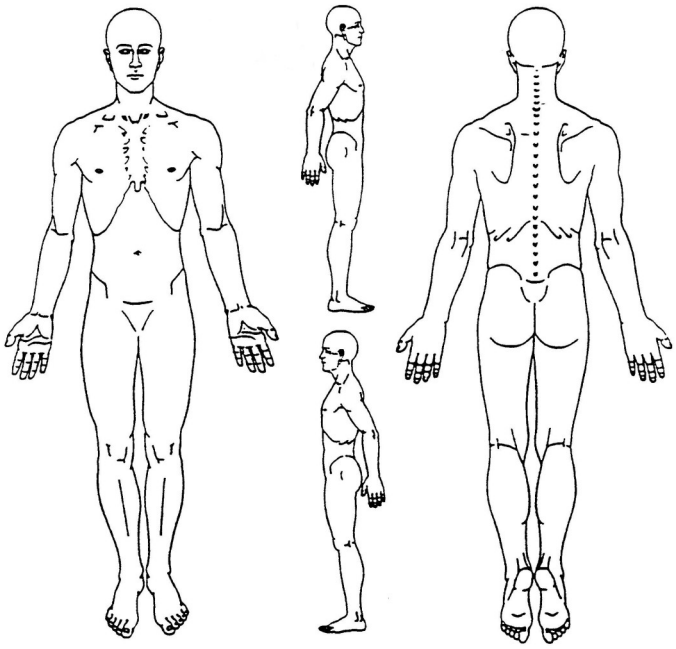
☐ Hospitalization ☐ Anti-Inflammatory ☐ Pain Medication ☐ Injection ☐ Heat/Ice ☐ Exercise ☐ Massage

☐ Other (please list) : _____

Please indicate the name of facility/physician and date of last visit: _____

On the diagram to the right, please indicate where you are experiencing your chief complaint by placing the letter(s) on the left on that specific area.

A: Ache **F:** Stiffness **T:** Tingling
B: Burning **N:** Numbness **X:** Sharp Pain
C: Cramping **R:** Throbbing
D: Dull Pain **S:** Soreness



Mark all activities that your chief complaint causes you to have trouble performing ? ☐ Standing ☐ Sitting

☐ Walking ☐ Running ☐ Bending ☐ Twisting

☐ Carrying objects ☐ Sleeping ☐ Driving ☐ Kneeling

☐ Lifting objects ☐ Lifting children ☐ Exercising

☐ Housework ☐ Personal Grooming

☐ Other : _____

Patient Name (please print): _____ Account # _____

Patient Signature _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

QUAD CITIES WELLNESS GROUP

2220 E. 53rd St ● Davenport, IA 52807 ● (O) : 563 - 355 - 3100 ● (F) : 888 - 534 - 6920

Social History

Marital Status? ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have children? ☐ Yes ☐ No If yes, what are their ages: _____

Are you, or could you be, pregnant? ☐ Yes ☐ No

What was the first day of your last menstrual cycle? _____

Risk Factors

Do you smoke or use tobacco? ☐ Daily ☐ Occasionally ☐ Former ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No If yes, indicate quantity: _____ drink per ☐ Day ☐ Week ☐ Month

Do you Exercise? ☐ Yes ☐ No What type?: _____ How many days per week? _____

Family History (check all that apply) ☐ None apply

Condition	Family Member (s)	Condition	Family Member(s)
☐ Heart disease	_____	☐ Scoliosis	_____
☐ Stroke	_____	☐ Spine problems	_____
☐ High Blood Pressure	_____	☐ Kidney failure	_____
☐ Diabetes	_____	☐ Mental illness	_____
☐ Osteoporosis	_____	☐ Bleeding disorders	_____
☐ Rheumatoid Arthritis	_____	☐ Anemia	_____
☐ Osteo Arthritis	_____	☐ Alcohol dependence	_____
☐ Lupus	_____	☐ Cancer	_____
☐ Sickle Cell	_____	☐ Other: _____	_____

Medications / Supplements you take ☐ None apply

Name	Dosage & Frequency	Who prescribed	Reason for taking

Patient Name (please print): _____ Account # _____

Patient Signature _____ Date: _____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.