

# Tree of Life Chiropractic Wellness Center

Peter R. Raether, DC  
Doctor of Chiropractic, LLC



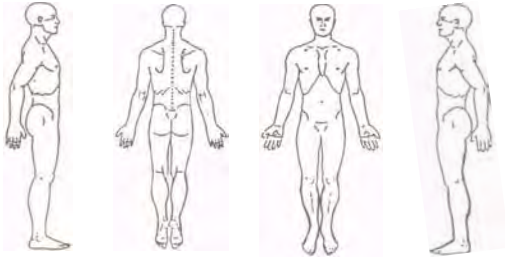
3823 S. 108<sup>th</sup> Street  
Greenfield, WI 53228  
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## PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Is today's problem caused by:**  Auto Accident  Workman's Compensation

2. **Indicate on the drawings below where you have pain/symptoms:**



3. **How often do you experience your symptoms:**

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. **How would you describe the type of pain?**

- Sharp  Numb  Dull  Tingly  
 Diffuse  Achy  Sharp with motion  Shooting with motion  
 Burning  Shooting  Stabbing with motion  Electric-like with motion  
 Stiff  Other: \_\_\_\_\_

5. **How are your symptoms changing with time:**

- Getting worse  Staying the same  Getting better

6. **Using a scale from 0-10 (10 being the worst), how would you describe your problem?**

0 1 2 3 4 5 6 7 8 9 10 (please circle)

7. **How much has the problem interfered with your work?**

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. **How much as the problem interfered with your social activities?**

- Not at all  A little bit  Moderately  Quite a bit  Extremely

9. **Who else have you seen for your problem:**

- Chiropractor  Neurologist  Primary Care Physician  
 ER Physician  Orthopedist  Other: \_\_\_\_\_  
 Massage Therapist  Physical Therapist  No one

10. **How long have you had this problem?** \_\_\_\_\_

11. **How do you think your problem began?** \_\_\_\_\_

12. **Do you consider this problem to be severe?**

- Yes  Yes, at times  No

13. **What aggravates your problem?** \_\_\_\_\_

14. **What alleviates or reduces your problem?** \_\_\_\_\_

15. **What concerns you the most about your problem? What does it prevent you from doing?** \_\_\_\_\_

16. **What is your:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation: \_\_\_\_\_

**17. How would you rate your overall health?**

- Excellent     Very good     Good     Fair     Poor

**18. What type of exercise do you do?**

- Strenuous     Moderate     Light     None

**19. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis     Diabetes     Lupus  
 Heart Problems     Cancer     ALS

**20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, please a check in the "present" column.**

Past/ Present	Past/ Present	Past/ Present
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Neck Pain	<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> <input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> <input type="checkbox"/> Chest Pains	<input type="checkbox"/> <input type="checkbox"/> Frequent Urination
<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/> <input type="checkbox"/> Low Back Pain	<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/> <input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Stones	<input type="checkbox"/> <input type="checkbox"/> Allergies
<input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> <input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Wrist Pain	<input type="checkbox"/> <input type="checkbox"/> Bladder Infection	<input type="checkbox"/> <input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> <input type="checkbox"/> Hand Pain	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Hip Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/> <input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> <input type="checkbox"/> Prostate Problems	
<input type="checkbox"/> <input type="checkbox"/> Knee Pain	<input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss	<b>For Females Only</b>
<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> <input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> <input type="checkbox"/> Jaw Pain	<input type="checkbox"/> <input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/> <input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> <input type="checkbox"/> Ulcer	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder	
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> General Fatigue	
<input type="checkbox"/> <input type="checkbox"/> Tumor	<input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination	
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Visual Disturbances	
<input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> <input type="checkbox"/> Dizziness	

**21. List all prescription medications you are currently taking:** \_\_\_\_\_

**22. List all of the over-the-counter medications you are currently taking:** \_\_\_\_\_

**23. List all surgical procedures you have had:** \_\_\_\_\_

**24. What activities do you do at work?**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> <b>Sit:</b>           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> <b>Stand:</b>         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> <b>Computer work:</b> | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> <b>On the phone:</b>  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

**25. What activities do you do outside or work?** \_\_\_\_\_

**26. Have you been seen by a chiropractor before?**  No  Yes  
If yes, how long ago? \_\_\_\_\_ Did you have a good experience? \_\_\_\_\_

**27. Have you ever been hospitalized?**  No  Yes  
If yes, why? \_\_\_\_\_

**28. Have you had significant past trauma?**  No  Yes

**29. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## LOWER BACK PAIN INDEX

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

### SECTION 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

### SECTION 2 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than  $\frac{1}{4}$ .
- Because of pain, my normal night's sleep is reduced by less than  $\frac{1}{2}$ .
- Because of pain, my normal night's sleep is reduced by less than  $\frac{3}{4}$ .
- Pain prevents me from sleeping at all.

### SECTION 3 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than  $\frac{1}{2}$  hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

### SECTION 4 – Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than  $\frac{1}{2}$  hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

### SECTION 5 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than  $\frac{1}{2}$  mile without increasing pain.
- I cannot walk more than  $\frac{1}{4}$  mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 6 – Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

### SECTION 7 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

### SECTION 8 – Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

### SECTION 9 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- Pain has restricted my social life and I do not go much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

### SECTION 10 – Changing Degrees of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

# NECK/UPPER BACK PAIN INDEX

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

## SECTION 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

## SECTION 2 – Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

## SECTION 3 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all due to pain.

## SECTION 4 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

## SECTION 5 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can not do any work at all.

## SECTION 6 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

## SECTION 7 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights.
- I cannot lift or carry anything at all.

## SECTION 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all.

## SECTION 9 – Recreation

- I am able to engage in all my recreation activities with no
- I have moderate headaches that come infrequently. neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

## SECTION 10 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

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## REGISTRATION

Date \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Patient \_\_\_\_\_ Cell # \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
 Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Relationship to Insured  Self  Spouse  Child  Other  
 Condition Related to  Illness  Employment  Auto  Other

<b>Employer</b>	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
<b>Spouse</b>  - or -  <b>Responsible Party</b>	Name _____ Last Name _____ First Name _____ Initial _____ Birthdate _____ Social Security # _____ - _____ - _____ Address _____ City _____ State _____ Zip _____ Employer Name _____ Occupation _____
<b>Other Information</b>	Is this your first visit to a Chiropractor? _____ Referred by: _____ Area of your present pain: _____ Have you been treated by another doctor for this complaint? _____ If this is due to an accident other than Auto or Work Comp, please describe: _____ Family Physician: _____ Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No List medication(s) you are taking: _____ Hobbies: _____ Emergency contact: _____ Phone: _____

(OVER)

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

and assign directly to Peter R. Raether, LLC all medical 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 my insurance submissions.

\_\_\_\_\_  
Signature of Insurance/Guardian

\_\_\_\_\_  
Date

**X-RAY CONFIRMATION:** This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant and I consent to spinographic pictures.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD:** I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**FINANCIAL/INSURANCE POLICY:** I understand and agree that health and accident insurance policies are an arrangement between in insurance carrier and myself. Furthermore, I understand that the Doctor's Office will process 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION:

To: Peter R. Raether, D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_