Fenske Holistic Healthcare Center (608) 836-8883

Patient Information

Name (last, first) _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ Phone (cell) _____ Email _____

Sex ____ Age_____ Date of Birth _____ Spouse/Partner's Name _____

Children (ages, names) _____

Occupation _____ Employer/School _____

How did you hear about our office? _____

Are you covered by MEDICARE? **Yes** ☐ / **No** ☐ Medicare number _____

Are you covered by MEDICAID or BADGERCARE?

NOTE: we are not a Medicaid/Badgercare provider and you will not receive reimbursement.

Is this an AUTO ACCIDENT case? **Yes** ☐ / **No** ☐

Is this a WORKER'S COMP case? **Yes** ☐ / **No** ☐ Please provide contact information for the person at your place of employment that is authorized to accept liability for this case: _____

Fee Schedule – Chiropractic Services

Initial Exam and Office Visit (45-60 minutes):	$164	(Children under 18: $147)
Follow-up Office Visit (about 15 minutes):	$54	(Children under 18: $44)
Follow-up Office Visit, Extended (about 30):	$84	

Our goal at Fenske Holistic Healthcare Center is to provide high quality, personal service that is responsive to the healthcare needs of our patients. We **require payment for services at the time they are provided** because we feel this allows us to focus on healthcare and not be distracted or influenced by the ever-changing time, monetary, and procedural restrictions of insurance providers. A high quality, informed interaction between a patient and practitioner requires time not only for a physical exam, but also for discussions regarding lifestyle and emotional concerns that are essential to providing comprehensive, holistic care. Every patient is a unique individual and Dr. Fenske will take the time to get to know and treat the individual in an effort to more effectively address the cause of health problems and not merely the symptoms. ***Please note, insurance companies generally cover 'structural' Chiropractic work but not Functional Medicine/Nutritional consultations, nutritional supplements, or preventative lab services.*** Any specific questions you may have about coverage for our services should be directed to your insurance company.

Please note that prices are subject to change without notice, the duration of each visit is approximate, and 24-hour notice is required to cancel an appointment without incurring a charge. Prices not only reflect the time spent with each patient but also the advanced training, expertise, and effort required to treat complex health conditions. We accept payment by cash, check, or credit card (MasterCard or Visa).

X Patient Signature _____ Date _____

Parent/Guardian _____ Date _____

(The signature of Parent/Guardian hereby authorizes Dr. Nicole Fenske to provide care for the minor child listed above.)

Fenske Holistic Healthcare Center (608) 836-8883

Patient Health History

Chiropractic

Name_____ **Date**_____

Date of Birth _____ **Age** _____ **Height** _____ **Weight** _____

Race/Ethnicity: ☐**Caucasian** ☐**African American** ☐**Asian** ☐**Hispanic** ☐**Native American** ☐**Other**

List your major concerns along with the cause(s) and what improves or aggravates them (if known or suspected). Also include prior treatments:

1.

2.

Are your health concerns interfering with *(check all that apply)*:

☐ Work ☐ Daily Routine ☐ Sleep ☐ Other _____

Mark the table below with an 'X' in the appropriate box to indicate location, type and severity (for severity use a scale of 1 to 10 with 10 being the most severe pain).

	Pain: ache	**Pain: sharp**	**Pain: radiating**	**Pain: constant**	**Pain: intermittent**	**Tight-ness**	**Numb-ness**	**Severity (1-10)**
Head								
Neck								
Upper back								
L shoulder								
R shoulder								
Mid back								
Low back								
Abdomen								
L hip								
R hip								
L knee								
R knee								
L ankle								
R ankle								
L foot								
R foot								
Other								

Please list other practitioners seen for these concerns: (or check here for none: ☐)

Name Date (approx.) Testing/Treatment

1. _____

2. _____

Additional remarks about previous treatment:

_____

List all medications you are currently using, or have used recently. Include all over-the-counter medications. List dosages and approximate length of time you have used each medication:

_____

_____

_____

_____

List (include name, brand, dosage) all vitamins, minerals, herbs, and other natural products you are currently using:

_____

_____

_____

_____

List medication/supplement/environmental allergies or intolerances and associated reactions:

_____

_____

_____

_____

Illness / Conditions History

Please mark the appropriate box with an 'X' if these symptoms occur presently or have occurred in the past 6 months. Leave blank any spaces that do not apply.

GASTROINTESTINAL	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other:_____		

RESPIRATORY	Yes	Past
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other: _____		

URINARY/GENITAL	Yes	Past
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other: _____		
ENDOCRINE/METABOLIC		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyr.)		
Polycystic Ovarian Syndrome		
Infertility		
Metabolic syndrome/insulin resist.		
Eating disorder		
Hypoglycemia		
Other: _____		
INFLAMMATORY/IMMUNE		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		
Other: _____		
MUSCULOSKELETAL		
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other: _____		

SKIN	Yes	Past
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other: _____		
CARDIOVASCULAR		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, tri-glycerides)		
Rheumatic fever		
Arrythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other: _____		
NEUROLOGIC/EMOTIONAL		
Epilepsy/Seizures		
ADD/ADHD		
Headaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other: _____		
CANCER		
Lung		
Breast		
Colon		
Ovarian		
Skin		
Other: _____		

Surgical History

Please list all major and minor surgeries you have undergone with approximate dates:

_____

_____

_____

List Any Serious Accidents or Falls

_____

_____

Family Health History

Review the conditions below. Indicate if a family member has ever had a condition by marking the appropriate box with an 'X'. Leave blank any spaces that do not apply.

CONDITION **current age(s) >**	**Father**	**Mother**	**Spouse**	**Brother(s)**	**Sister(s)**	**Children**
Acne						
Alcoholism/addiction						
Allergies/hay fever						
Alzheimer's Disease / Dementia						
Arthritis						
Asthma						
Autoimmune disease						
Bedwetting						
Cancer (*specify type* _____)						
Depression						
Diabetes						
Digestive problems						
Ear infections						
Female problems						
Headaches						
Heart disease						
High blood pressure						
Insomnia						
Kidney problems						
Liver disease						
Mental health problems						
Migraine						
Muscle pain/cramps						
Osteoporosis						
Spinal curve						
Thyroid problems						
Other (*specify* _____)						
Other (*specify* _____)						
If any of the above family members are deceased, specify cause of death…						
…and list their age at death						
Other pertinent family history:						

Stress Factors

Please list any major stress factors in your life:

_____

_____

_____

Lifestyle/Diet Habits

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No
Describe your sleep pattern: Time arise _____ Time retire _____ Naps? ☐ Yes ☐ No
Your quality of sleep is: ☐ Well-rested ☐ Tired upon awakening ☐ Awaken during night
Do you: ☐ Sleep in total darkness ☐ Sleep near electric clock, outlet, or other electronic device
What is the frequency of your vacations: ____ times / year.
Do you exercise? ☐ Yes ☐ No
If *yes*… Type: _____ Frequency: ____ x per ☐ week / ☐ month (*check one*).
Do you use tobacco? ☐ Yes ☐ No If *yes*, list amount you smoke/chew per day or week _____
Years using tobacco _____, if you no longer use it, when did you quit _____
Do you use recreational drugs? ☐ Yes ☐ No
If *yes*, list type and frequency _____
Did you formerly use recreational drugs? ☐ Yes ☐ No If *yes,* specify _____
How frequently do you dine out: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How frequently do you eat fast food: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely/never
How much water do you drink daily: ☐ < 1 qt. ☐ 1 qt. ☐ 2 qt. ☐ > 2qt.
Is it filtered water? ☐ Yes ☐ No
Foods you avoid and why
(*i.e.* allergies, diet, dislike): _____
Foods you crave: _____
Do you have (or have you had) an eating disorder? ☐ Yes ☐ No
Do you drink coffee? ☐ Yes ☐ No
If *yes*, how many daily cups daily of decaf? _____ and caffeinated? _____
Do you drink tea? ☐ Yes ☐ No
If *yes*, what kind? _____ and how many cups do you drink daily? _____
Do you drink soda? ☐ Yes ☐ No
If *yes*, what kind? _____ and how many do you drink daily? _____
Do you drink alcohol? ☐ Yes ☐ No
If *yes*, list type and amount per day and week _____
Do you have (or have you had) a problem with alcohol or drug overuse? ☐ Yes ☐ No