WELLNESS CENTER GRAND MARAIS

Loren R. Stoner, D.C.
Grand Marais Wellness Center
PO Box 125
Grand Marais, MN 55604-0125
218-387-9494 phone
218-387-3584 fax
grandmaraischiro.com

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | **Your Middle Name (or Initial)** | **Birth Date (MM/DD/YYYY)**

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | **State/Province** | **ZIP/Postal Code** | **Home Phone** | **Spouse's Name**

Email Address | **Cell Phone** | **Child's Name and Age**

Emergency Contact | **Phone** | **Child's Name and Age**

Your Occupation | **Child's Name and Age**

Your Employer

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Address

City | **State/Province** | **ZIP/Postal Code** | **Work Phone**

Insurance Carrier | **Policy Number** | **Primary Care Provider's Name**

Insured's Last Name | **Birth Date (MM/DD/YYYY)**

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | **Middle Name (or Initial)**

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

I certify that any changes to my personal information have been updated above for your records.

Signature

UPDATED CONTACT INFORMATION

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UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) ____________________

Your Last Name ____________________ **Your First Name** ____________________ **Your Middle Name (or Initial)** ____________________

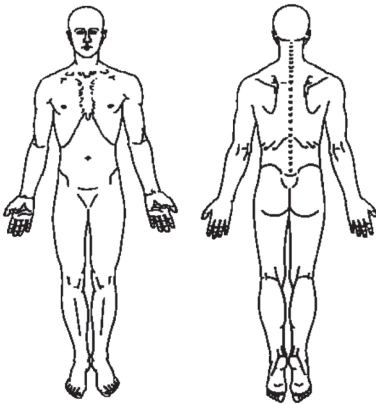
○ **I have new contact information**

Please select one:

○ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
○ **New condition** – I've been under care and a new or returning condition has emerged.
○ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
○ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: ____________________

1. Location (Where does it hurt?)
Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other

3. Intensity (How extreme are your current symptoms?)

Absent — Uncomfortable — Agonizing

4. Duration and Timing (When did it start and how often do you feel it?)

○ Constant ○ Come and goes.

When did it start and how often? ____________________

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

____

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? ____________________

What tends to lessen the problem? ____________________

7. Prior interventions (What have you done to relieve the symptoms?)

○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other ____________
○ Physical therapy ○ Massage ____________

8. What else should Dr. Stoner know about your current condition?

____

____

____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	○	○	○
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	○	○	○
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	○	○	○
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	○	○	○
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	○	○	○
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	○	○	○
g. Integumentary System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	○	○	○
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	○	○	○
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	○	○	○
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	○	○	○

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: ____________________

____

____

This updated patient history is for:

○ Current Patient
Periodic Re-evaluation

○ Current Patient
Additional Complaint/
Exacerbation

○ Maintenance Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

○ Inactive Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

Consultation Notes

UPDATED PATIENT HISTORY

Doctor's Initials ____________

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11. Social History (Tell Dr. Stoner about your health habits and stress levels.)

Alcohol use	◯ Daily	◯ Weekly	How much?________
Coffee use	◯ Daily	◯ Weekly	How much?________
Tobacco use	◯ Daily	◯ Weekly	How much?________
Exercising	◯ Daily	◯ Weekly	How much?________
Pain relievers	◯ Daily	◯ Weekly	How much?________
Soft drinks	◯ Daily	◯ Weekly	How much?________
Water intake	◯ Daily	◯ Weekly	How much?________

Hobbies: ________

Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

13. Is there anything else Dr. Stoner should know about your current condition, your progress or ways your current condition is affecting your life?

____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: ________

Signature ________ Date (MM/DD/YYYY) ________

Patient name

Consultation Notes

Doctor's Initials

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