

Confidential Patient Information

Name _____
 Preferred name (nickname) _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____
 Cell Phone _____
 Age _____ Birth Date _____
 Social Security _____
 Marital Status M S D W # of children _____
 Occupation _____
 Employer Name _____
 City _____ State _____ Zip _____
 Work Phone _____ Ext. _____

Referral / Physician Information

TV Newspaper Phone book Internet Location
 Family Friend Physician
 Referred By (Name) _____
 Primary Care Physician _____
 City _____

Emergency Contact Information

Spouse/Other _____
 Occupation _____
 Employer _____
 Mobile/Work Phone _____
 Are you Insured? Yes No
 Company Name _____

Reason for This Appointment

Condition / Symptoms _____
 Have you seen other doctors for this condition? Yes No Doctor's Name(s) _____
 Prior treatment: MRI CT Scan X-rays Medication Physical Therapy Other treatment _____
 Results _____
 Have you been treated by a Chiropractor before? Yes No How long ago? _____

Check any items below that you have experienced:

- | | | |
|--|--|---|
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Loss of bowel or bladder control |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Weakness in Arms or Legs |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood Clots/Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| Surgeries/Hospitalizations: | Medications: | Other Medical Conditions: |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Family History: Cancer Diabetes Rheumatoid Arthritis High Blood Pressure Heart Problems Stroke

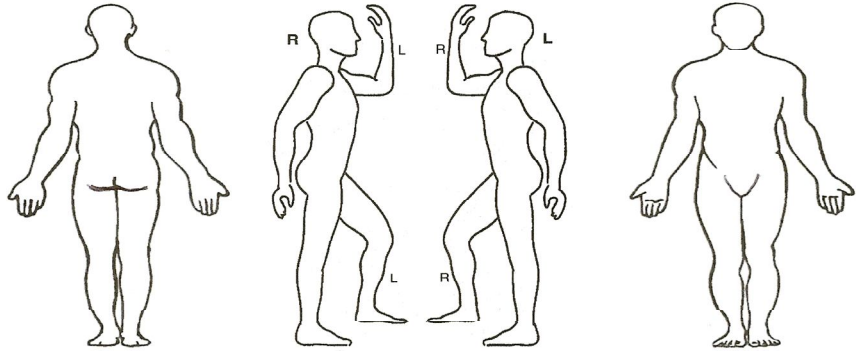
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Boehmer and Korhuis Chiropractic Inc will make reasonable efforts to collect from my insurance company. However, I clearly understand that I am personally responsible for payment. Payment and/or copayment is expected at time of service.

Patient's Signature _____ Date _____
 Guardian or Spouse Signature _____ Date _____

Name _____

In the figures to the right, please indicate where you have symptoms. Use the following key:

Pain = X X X
Numbness or Tingling = ≡



How long have you had this symptom? _____

If you have had symptoms in this area before, when did it first occur? _____

Please describe how your pain began: _____ Don't know

Back Pain: If you have back pain please describe:

How often do you have BACK symptoms:

- 100-75% 75-50% 50-25% 25% or less

Describe BACK symptoms: (OK to check more than one)

- Dull / Ache Soreness Pressure Tightness
- Throbbing Burning Spasms Sharp/Stabbing
- Numbness Tingling Weakness

Other: _____

My BACK symptoms are:

- Getting Worse Getting Better
- Up and Down Not Changing

BACK made worse by: (OK to check more than one)

- Sitting Standing Walking Bending
- Lifting Sleeping Twisting / Turning
- Physical Activity Not changing

Relieved By: _____

Neck Pain: If you have neck pain, please describe:

How often do you have NECK symptoms:

- 100-75% 75-50% 50-25% 25% or less

Describe NECK symptoms: (OK to check more than one)

- Dull / Ache Soreness Pressure Tightness
- Throbbing Burning Spasms Sharp/Stabbing
- Numbness Tingling Weakness

Other: _____

My NECK symptoms are:

- Getting Worse Getting Better
- Up and Down Not Changing

NECK made worse by: (OK to check more than one)

- Sitting Standing Walking Bending
- Lifting Sleeping Twisting / Turning
- Physical Activity Not changing

Relieved By: _____

Headaches: If you have headaches, please describe:

How often do you have HEADACHES:

- Daily 3-5x/week 2-3x/week 1x/week

Describe HEADACHES: (OK to check more than one)

- Dull / Ache Pressure Tightness Throbbing
- Sharp/Stabbing Tingling Visual blurring

Other: _____

My HEADACHES are:

- Getting Worse Getting Better
- Up and Down Not Changing

HEADACHES worse with: (OK to check more than one)

- Stress Work Computer work
- Menstral Cycle Not changing

Relieved By: _____

Life Impact Survey

Please describe how your life has been impacted by this condition

Work:

What is your primary function at work? _____

Do you ever need to ask for help? Yes No

Are there any parts of your job you find yourself shying away from? _____

Have you ever had to miss work? Yes No How many days? _____

Household Chores/Yard Work:

Are there any chores you are now avoiding/shying away from? Yes No

Do you have to take more breaks to complete your chores? Yes No

Have you had to ask a family member/friend to assist with chores? Yes No

Have you considered hiring a person to do chores for you? Yes No

Recreational Activities /Exercise:

What recreational activities/exercise are you involved in?

Are there any activities you find yourself shying away from? Yes No (Circle above if applicable)

Relationships:

What activities or things do you usually do with your Spouse/Children/Friends?

Have you been avoiding going out with friends or family because of your pain? Yes No

Do you find yourself avoiding playing with/holding children or grandchildren? Yes No

Do you think your spouse or family might say you have been less patient than usual? Yes No

Are there any other areas of your life affected by this condition? _____

***** Office Use Only *****

_____ x Day/Wk _____ Min/Hrs Now: _____ x/_____

_____ x Day/Wk _____ Min/Hrs Now: _____ x/_____

_____ x Day/Wk _____ Min/Hrs Now: _____ x/_____

_____ x Day/Wk _____ Min/Hrs Now: _____ x/_____

Sit: ___Shift ___Stand Stand: ___Shift ___Sit ___Lay

Walk: ___Sit ___Lay Sleep: ___Wake ___Hrs