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:

□ Unexplained weight loss
□ Fever
□ Night Sweats
□ Chest Pain
□ Fatigue
□ Dizziness
□ Fainting

□ Rheumatoid Arthritis
□ Pacemaker/Defibrillator
□ High Blood Pressure
□ Stroke
□ Cancer_____
□ Blood Clots/Disorders
□ Stroke

□ Loss of bowel or bladder control
□ Weakness in Arms or Legs
□ Numbness
□ Difficulty Swallowing
□ Osteoporosis
□ Tuberculosis
□ 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 Korthuis 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 _____

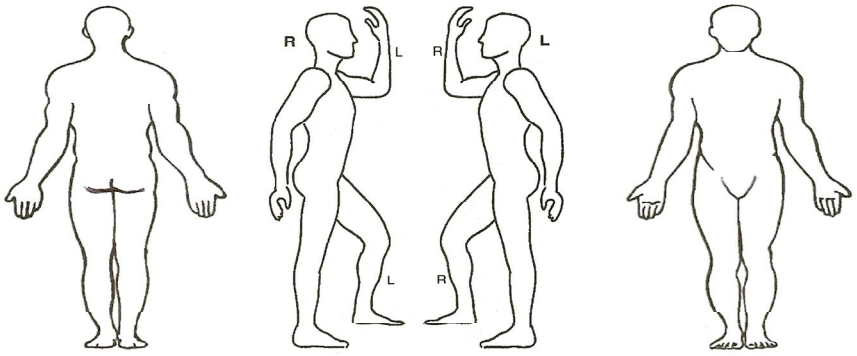
Guardian or Spouse Signature_____ Date _____

Name_____

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

Pain = X X X

Numbess 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

My BACK symptoms are:
□ Getting Worse □ Getting Better
□ Up and Down □ Not Changing

Describe BACK symptoms: (OK to check more than one)
□ Dull / Ache □ Soreness □ Pressure □ Tightness
□ Throbbing □ Burning □ Spasms □ Sharp/Stabbing
□ Numbness □ Tingling □ Weakness

BACK made worse by: (OK to check more than one)
□ Sitting □ Standing □ Walking □ Bending
□ Lifting □ Sleeping □ Twisting / Turning
□ Physical Activity □ Not changing

Other: _____

Relieved By:_____

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

How often do you have NECK symptoms:

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

My NECK symptoms are:
□ Getting Worse □ Getting Better
□ Up and Down □ Not Changing

Describe NECK symptoms: (OK to check more than one)
□ Dull / Ache □ Soreness □ Pressure □ Tightness
□ Throbbing □ Burning □ Spasms □ Sharp/Stabbing
□ Numbness □ Tingling □ Weakness

NECK made worse by: (OK to check more than one)
□ Sitting □ Standing □ Walking □ Bending
□ Lifting □ Sleeping □ Twisting / Turning
□ Physical Activity □ Not changing

Other: _____

Relieved By:_____

Headaches: If you have headaches, please describe:

How often do you have HEADACHES:

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

My HEADACHES are:
□ Getting Worse □ Getting Better
□ Up and Down □ Not Changing

Describe HEADACHES: (OK to check more than one)
□ Dull / Ache □ Pressure □ Tightness □ Throbbing
□ Sharp/Stabbing □ Tingling □ Visual blurring

HEADACHES worse with: (OK to check more than one)
□ Stress □ Work □ Computer work
□ Menstral Cycle □ Not changing

Other:_____

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