BEHRMAN CHIROPRACTIC

Name:_____ Todays Date:_____

Age:_____ Date of Birth:_____ Gender:_____

Address:_____ City, State:_____ Zip Code:_____

Email Address:_____ Primary Doctor:_____

Marital Status:_____ Spouse's Name:_____

Emergency Contact Name and Phone Number:_____

Occupation:_____ Work Activity: Sitting _____ Standing _____ Manual Labor _____

Do you plan on using medical insurance?: Y or N Insurance Company:_____

Insurance Member ID:_____ Group Number:_____

How did you hear about our office? Referral:_____ Doctor___ Website___ Other___

PRESENT CONDITION

Are you here because of: Work Injury? Yes____ No____ Auto Accident? Yes____ No____

What is the reason you are seeing us today? Where are you feeling the problem?_____

_____

When did this start? _____ How did it start?_____

Have you had this similar condition before? Y:_____ N_____

How bad is your pain/ache? Please circle (0=no pain 10=most pain) 0 1 2 3 4 5 6 7 8 9 10

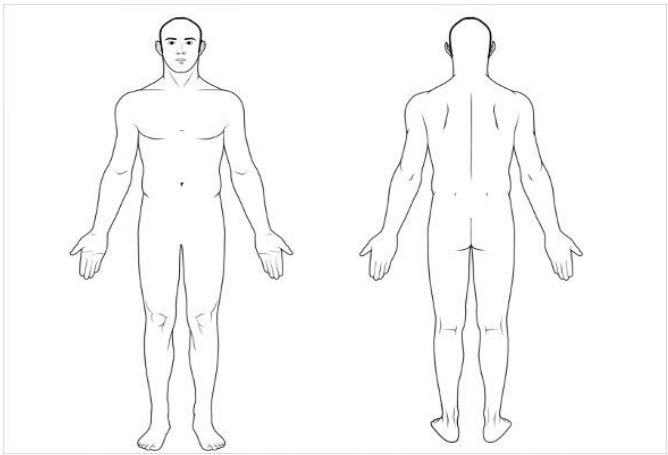
How frequent is your problem? Constant _____ Frequent _____ Occasional _____ Comes & Goes _____

What activities aggravate your condition?_____

Do you feel your condition is getting: Worse_____ Better_____ No change_____

Please indicate on the body diagram, using the appropriate symbols, where you are having symptoms.

P-Pain
N-Numbness
W-Weakness
S-Shooting
A-Aching



Have you ever been to a chiropractor before?: No_____ Yes (name):_____

List previous treatments for this condition:_____

Do you smoke?: Yes_____ No____ Do you exercise?: Yes (activities)_____ No____

Rate your sleep, hours per night: <4 4-6 6-8 8-10 12+

Rate your diet: Poor Fair Medium Good Excellent

Please list all medications you are currently taking:_____

_____

Please list any surgeries/operations:_____

Please list any familial medical conditions: (ex Diabetes, Stroke, High Blood Pressure, Cancer, Heart Disease)

_____

PLEASE REVIEW AND INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS
P = PREVIOUS O = OCCASIONAL F = FREQUENT

GENERAL

____ dizziness

____ fainting

____ headaches

____ loss of sleep

____ depression

____ numbness

____ loss of weight

PAIN OR NUMBNESS IN:

____ arms

____ hands

____ hips

____ legs

____ knees

____ ankles

____ feet

____ tailbone

____ sciatica

____ shoulders

RESPIRATORY

____ chest pain

____ chronic cough

____difficulty breathing

CARDIOVASCULAR

____ rapid heartbeat

____ swelling of ankles

____ hardening of arteries

____ high blood pressure

____ low blood pressure

EARS, NOSE, & THROAT

____ ear aches

____ ear ringing

____ sinus infections

____ hoarseness

GASTROINTESTINAL

____ constipation

____ diarrhea

____ difficult digestion

____ stomach pain

____ nausea

____ vomiting

SKIN

____ bruise easily

____ hives or allergies

GENITOURINARY

____ blood in urine

____ urine leakage

____ painful urination

WOMEN ONLY:

___ cramps

____ irregular cycle

____ painful cycle

Pregnant: Y or N

EDD:_____