# BEHRMAN CHIROPRACTIC

Name:_____ Todays Date:_____

Phone Number:_____ Age:_____ Date of Birth:_____Gender:____

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

Email Address:_____ Primary Doctor:_____

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 _____

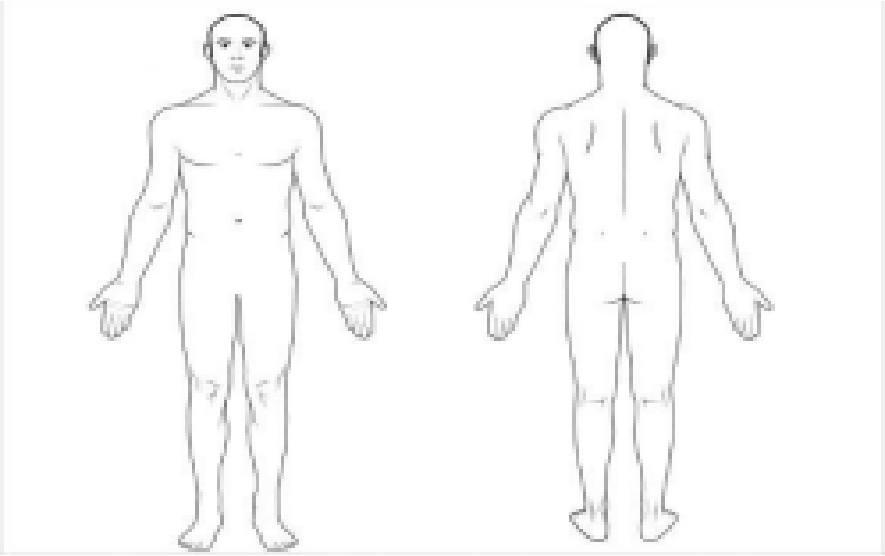
What activities aggravate your condition?_____

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 THE FOLLOWING SYMPTOMS IN THE PAST 3 MONTHS
P = PREVIOUS O = OCCASIONAL F = FREQUENT

**GENERAL:**
_____ dizziness
_____ fainting
_____ headaches
_____ loss of sleep
_____ depression
_____ numbness
_____ loss of weight

**PAIN/NUMBNESS:**
_____ 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

**SKIN:**
_____ bruise easily
_____ hives or allergies

**GASTROINTESTINAL:**
_____ constipation
_____ diarrhea
_____ difficult digestion
_____ stomach pain
_____ nausea
_____ vomiting

**GENITOURINARY:**
_____ blood in urine
_____ urine leakage
_____ painful urination

**WOMEN ONLY:**
____ cramps
_____ irregular cycle
_____ painful cycle
Pregnant: Y or N
EDD:_____