BALLAS CHIROPRACTIC & NUTRITION CENTRE

Dr. David K. Wipperman

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Name ______ Last ______ First ______ Middle Initial

Address ______ City ______ State ______ Zip

Referred by ______________________

Home Phone (______)______________

Patient's Social Security No. ______________________

Work Phone (______)______________

Occupation ______________________

E-mail Address ______________________

No. of Children ______________

Date of Birth _____ - _____ - _____ Sex ☐ M ☐ F Marital Status ☐ M ☐ S ☐ W ☐ D

Employer's Name ______________________

Insurance Plan Name or Program Name ______________________

Patient Relationship to Insured (check one) ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insured's Name ______________________

Spouse's Name ______________________ Spouse's Soc. Sec. No. ______________

Spouse's Employer ______________________ Work Phone (______)______________

In case of emergency, another nearest relative not living with you:

Name ______________________ Phone (______)______________

Family Physician's Name/Address ______________________

YOUR BACKGROUND OF ACCUMULATIVE FACTORS CONTRIBUTING TO DECLINING HEALTH

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting before birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS (to age 15)	YES	NO	COMMENTS:
Were you vaccinated?	☐	☐	
Did you have any childhood illnesses?	☐	☐	
While learning to walk, did you fall head first?	☐	☐	
Have you fallen/jumped from a height over three feet? (i.e., crib, bunk bed, trees)	☐	☐	
Did you play youth sports?	☐	☐	
Did you take/use any drugs?	☐	☐	
Did you have any surgery?	☐	☐	
Were you involved in any car accidents as a child?	☐	☐	
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	
Did you suffer any other traumas (physical or emotional)?	☐	☐	
As a child, were you under regular Chiropractic care?	☐	☐	

YOUR ADULT YEARS (age 15 to present)	YES	NO	COMMENTS
Do / did you smoke?	☐	☐	
Do / did you drink alcohol?	☐	☐	
Have you been in any accidents?	☐	☐	
Have you had any surgery?	☐	☐	
Do / did you play any adult sports / extreme sports?	☐	☐	
Did you suffer any other traumas (physical or emotional)?	☐	☐	

On a scale of 1-10 describe your stress level:
(1=None / 10 = Extreme)
Occupational ________ Personal ________

On a scale of Poor, Good, Excellent describe your:
Diet ________ Exercise ________ Sleep ________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

People who have already experienced Chiropractic Wellness Care and are here to continue, need only check here ☐ **"Wish to continue My Chiropractic Wellness Experience."** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

____

____

Describe your pain:
☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Problem started ____________________ ☐ It's getting better ☐ It's getting worse

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list):

☐ Chiropractor ____________________

☐ Medical Doctor ____________________

☐ Specialist ____________________

Please check (✓) all symptoms you have, even if they do not seem related to your current problem:

- ☐ Headaches
- ☐ Pins & Needles in Arms
- ☐ Dizziness
- ☐ Numbness in Fingers
- ☐ Fatigue
- ☐ Sleeping Problems
- ☐ Diarrhea
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Pins & Needles in Legs
- ☐ Loss of Smell
- ☐ Buzzing in Ears
- ☐ Numbness in Toes
- ☐ Depression
- ☐ Stiff Neck
- ☐ Constipation
- ☐ Lights Bother Eyes
- ☐ Menstrual Pain/Irregularity
- ☐ Fainting
- ☐ Back Pain
- ☐ Ringing in Ears
- ☐ Loss of Taste
- ☐ Irritability
- ☐ Cold Hands
- ☐ Fever
- ☐ Problem Urinating
- ☐ Cough/Sore Throat
- ☐ Neck Pain
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Upset Stomach
- ☐ Tension
- ☐ Cold Feet
- ☐ Hot Flashes
- ☐ Heartburn/Ulcers
- ☐ Upper Respiratory Infections

List any medication you are taking: ____________________

Health conditions of:

Children ____________________

Mother ____________________

Father ____________________

Siblings ____________________

X-RAY CONFIRMATION: This is to confirm that I have been advised by the Doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic examination.

Signed ____________________ Date __________

CONSENT TO TREAT MINOR/CHILD: I hereby authorize the Doctor to administer chiropractic care as deemed necessary to my ____________________ (indicate relationship to child)

Name ____________________

Signed ____________________ Date __________

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature ____________________ Date __________