GENERAL INFORMATION

Name ________________________________ Date ____________________

Address ________________________________ Care of ____________________
(Parent or financially responsible person)

City ________________ State ____ Zip ________ No. of Children ____________

Phone:(H)_________ (W)__________ (C)___________ (E-mail)______________

Spouse's Name _________________________ Referred by _________________

Sex	Marital Status	Date of Birth	Age	Social Security No.
M F	Married Single Widowed Divorced			

EMPLOYER ____________________	SCHOOL ____________________
☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	☐ Full Time ☐ Part Time

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Patient's Signature ______________________ Date ____________________

PATIENT HISTORY

Please fill in the appropriate spaces. (All information is confidential.)

MAJOR COMPLAINT: ____

____

____

How long have you had this complaint? ___________________________

Date of onset? ____

Was the injury accident related? ☐ Auto Accident ☐ Work Accident

Previous chiropractic care? Yes No Chiropractor's Name: ______________

____

What was the reason for initial visit? _____________________________

____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? ________________________________

____

Did you follow it?________________________ If not, why?______________________________
Why are you changing chiropractors?____
What surgeries have you had?____
____
List drugs you now take (prescription and non-prescription)____________________________
____
Family doctor's name, address and phone number? __________________________________
____
Last time seen and for what condition?____
What results would you want for yourself?____
Reduced pain______________ Restore health____________ Maintain health _____________

Please mark if any of these apply in the last 12 months?

_ Fractured bones
_ Auto Accident
___0-1 years ago
___1-5 years ago
___5 years or more
_ Other accidents, falls
_ Arthritis
_ Diabetes
_ Convulsions, epilepsy
_ Skin Problems
_ Cancer
_ Frequent colds, flu
_ Depressed
_ Irritable
_ Anemia
_ Allergy, Sinus
_ Under Stress
_ Eating Disorders
_ Trouble Sleeping
_ Trouble concentrating
_ Learning disability
_ Mood changes

_ Neck pain or stiffness R L
_ Numbness, tingling, pain
_ Arms, hands, fingers R L
_ Jaw pain or clicking (TMJ) R L
_ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
_ Shoulder pain R L
_ Dizziness
_ Ringing in ears R L
_ Hearing Loss
_ Blurred or double vision
_ Upper back pain, stiffness
_ Mid back pain, stiffness
_ Lower back pain, stiffness
_ Pain with cough, sneeze
_ Hip pain R L
_ Headaches

_ Numbness, tingling, pain,
_ In buttocks, legs, feet, toes
_ R L
_ Foot trouble R L
_ Chest pain, asthma
_ Heart problems
_ Stroke
_ High/low blood pressure
_ Varicose veins
_ Liver trouble
_ Gallbladder trouble
_ Digestive problems
_ Ulcers
_ Hemorrhoids
_ Prostrate problems
_ Impotence
_ Kidney trouble
_ Menstrual problems, PMS
_ Pregnant (now)
_ Bedwetting
_ Ear infections
_ AIDS, HIV

For women only…
Are you pregnant or is there a possibility you could be pregnant___
If x-rays are necessary for evaluation for my condition, I authorize them to be taken, (Please initial) _____

Consent to treat a minor

I hereby authorize Dr. Dennis S. Brickner of Brickner Chiropractic Health Center to administer chiropractic care to ____

Signed ______________________________ Date ____________________

Witness ____