

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 .
M F	Married Single Widowed Divorced		

EMPLOYER _____ SCHOOL _____

_____ Full Time _____Part Time
_____ Retired _____ Not Employed

_____Full Time _____ Part Time

I acknowledge that Brickner Chiropractic Health Center does not bill insurance providers . _____ (Initial)

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 _____