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Patient Information

First Name – *Required*

Last Name – *Required*

Email – *Required*

Preferred Name (if different)

Pronouns

Prefix / Title

Date of Birth – *Required*

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex – *Required*

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Marital Status:

Married Single Divorced Separated Widowed

Mobile Phone

US

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

State – *Required*

Postal / Zip – *Required*

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Current Health Conditions

Reason for visit:

When and how did it start?

Have you received care for this problem? If yes, please explain:

What makes the problem better?

What makes it worse?

Is the condition:

- [ ] Getting Worse
- [ ] Improving
- [ ] No Change

Is the condition:

- [ ] Intermittent (on and off)
- [ ] Constant
- [ ] Unsure

Describe the pain:

- [ ] Aching
- [ ] Sharp
- [ ] Numb
- [ ] Dull
- [ ] Burning
- [ ] Tingling
- [ ] Deep
- [ ] Throbbing
- [ ] Other

Rate your pain level

0 1 2 3 4 5 6 7 8 9 10

For Women Only:

Are you pregnant?:
Due Date:
Are you currently nursing?

Health History

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Indicate if YOU or any IMMEDIATE FAMILY members have any of the following:

- [ ] Rheumatoid Arthritis
- [ ] Diabetes
- [ ] Lupus
- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Stroke
- [ ] Cancer

If you selected yes to any of the previous, please specify who has/had the condition:

For each of the conditions listed below, please check the box if you have had the condition in the past or currently:

- [ ] Headaches
- [ ] Neck pain
- [ ] Upper back pain
- [ ] Midback pain
- [ ] Low back pain
- [ ] Shoulder pain
- [ ] Arm pain
- [ ] Wrist pain
- [ ] Hand pain
- [ ] Upper leg pain
- [ ] Hip pain
- [ ] Knee pain
- [ ] Ankle/Foot pain
- [ ] Jaw pain
- [ ] Joint swelling
- [ ] Arthritis
- [ ] Rheumatoid arthritis
- [ ] General fatigue
- [ ] Vision problems
- [ ] Ringing in the Ears
- [ ] Memory problems
- [ ] Broken bones
- [ ] Pacemaker
- [ ] Dizziness
- [ ] High Blood Pressure
- [ ] Heart Attack/disease
- [ ] Chest pain
- [ ] Stroke
- [ ] Angina
- [ ] Kidney Stones
- [ ] Kidney disorders
- [ ] Loss of Bladder Control
- [ ] Painful Urination
- [ ] Bladder infection
- [ ] Prostate Problems (Men only)
- [ ] Abnormal weight change
- [ ] Loss of appetite
- [ ] Abdominal pain
- [ ] Ulcer
- [ ] Hepatitis
- [ ] Tumor
- [ ] Gall Bladder problems
- [ ] Sensitivity to light
- [ ] Cold hands/feet
- [ ] Liver disease
- [ ] Thyroid problems
- [ ] Asthma
- [ ] Sinus problems
- [ ] Diabetes
- [ ] Excessive thirst
- [ ] Frequent urination
- [ ] Tobacco Use
- [ ] Drug/Alcohol dependence
- [ ] Allergies
- [ ] Depression/Anxiety
- [ ] Lupus (SLE)
- [ ] Epilepsy
- [ ] Dermatitis/Eczema/Rash
- [ ] Concussion
- [ ] Hormonal replacement
- [ ] Birth Control Pills
- [ ] Pregnancy
- [ ] Cancer
- [ ] Muscular incoordination
- [ ] Loss of balance
- [ ] Loss of concentration
- [ ] Anemia
- [ ] Osteoporosis
- [ ] Other

How do you normally sleep? Check all that apply.

- [ ] Back
- [ ] Side
- [ ] Stomach

Do you wake up:

- [ ] Refreshed
- [ ] Stiff & Tired

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Chiropractic History

What would you like to gain from chiropractic care?

- [ ] Resolve existing condition(s)
- [ ] Overall wellness
- [ ] Both

Have you ever visited a chiropractor before?

- [ ] Yes
- [ ] No

For what reason did you visit a chiropractor and did it help?

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each: (1 = never, 5 = high)

Alcohol

- [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Water

- [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Caffeine

- [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Cigarettes/Tobacco

- [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Recreational Drugs

- [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Allergies:

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking, and why:

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Traumas: Physical Injury History

Please list any significant falls, surgeries, accidents or injuries you've sustained.

Notable childhood injuries?

Have you ever been hospitalized?

- [ ] Yes
- [ ] No

If yes, why?

Thoughts: Emotional Stress

Please rate your STRESS for each: (1 = none, 5 = high)

Home

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Work

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Life

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Money

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Health

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Family

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5

Communication

Appointment Notifications and Reminders

Email

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [ ] I would like email notifications of new, cancelled, and rescheduled appointments

- [ ] Email 24 hours before appointment

Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

- [ ] Text Message (SMS) 24 hours before appointment

Consents

Accuracy of Information

- [ ] I certify that the above medical information is correct to my knowledge. *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

- [ ] I agree *Required*

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor's day that could have been filled by another patient. As such, we require **4 hours notice** for any cancellations or changes to your appointment. Patients who provide less than **4 hours notice**, or miss their appointment, will be charged a **cancellation fee of $50.00** at each occurrence.

- [ ] I am aware of the Cancellation Policy. *Required*

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Consent to Treat

I hereby authorize and consent to chiropractic treatments and procedures, including but not limited to: chiropractic adjustments, examinations, x-rays, and various modes of manual/physical therapies, stretching, massage, therapeutic ultrasound, electric muscle stimulation, hot or cold packs, traction, decompression, and exercise. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels, based upon the facts known, are in my best interest. Chiropractic treatment, including spinal manipulation, according to government reports and multi-disciplinary studies conducted over many years, has been demonstrated to be a highly effective treatment for back pain and musculoskeletal pain. I acknowledge that I have discussed, or had the opportunity to discuss, with either the doctor or staff, the risks and benefits of undergoing treatment; I have freely decided to undergo treatment, and hereby give my full consent to treatment. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

☐ I agree *Required*

Consent for Minor:

I acknowledge that I have read and understand the above consent to treat information and authorize and give consent to the doctor(s), staff, and doctor's assistance of Bjorlie Chiropractic to treat my minor child. As of today's date, I have the legal right to select and authorize health care service for the minor child named below.
If applicable, under the terms and conditions of my divorce, separation, or other legal authorization, the consent of the spouse, former spouse, or other parent is not required. If my authority to select and authorize this care should be revoked or modified in condition in any way, I will immediately notify this office.

☐ I agree

Signatures

_____ _____

Patient or Guardian Signature *Date*

_____

Patient or Guardian Printed Name

_____ _____

Witness Signature *Date*

_____

Witness Printed Name