

General Information

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

Phone: _____ Cell Home

Occupation: _____

Employer: _____

How did you hear about/find us? _____

Is this your first visit to a Chiropractor?

No Yes

Emergency Contact Info

Name: _____

Relationship: _____

Phone: _____ Cell Home

Dr.'s Notes

Reason for Visit

What brings you in today? _____

Have you received treatment for this condition in the past?

No Yes

If yes, where? _____

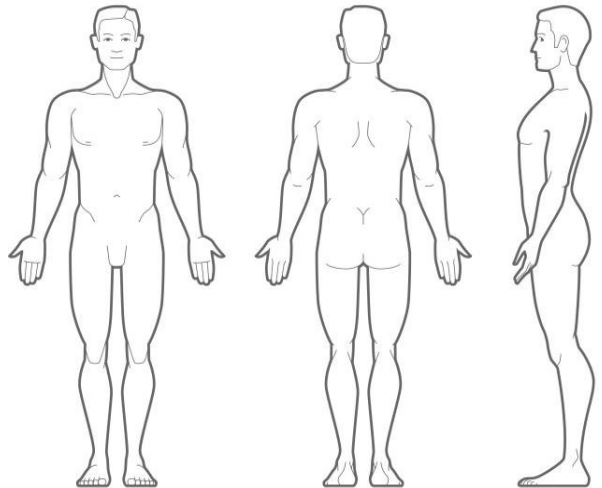
When? _____

Are you seeking treatment related to an accident?

Auto Work Other No

Using the symbols below, please mark any areas where you're experiencing:

× Pain ⊙ Numbness or Tingling # Burning



How severe is your pain on a scale of 0 to 10:

On Average? _____ At worst? _____ At best? _____

Check the boxes that best describe your symptoms:

Constant Comes & goes Worse at night

Worse in the morning Sharp Dull

Aching Shooting Throbbing Burning.

When did your symptoms first appear? _____

What (if anything) makes it better? _____

What makes it worse or irritates it? _____

Health History

Recent signs & symptoms: (Please check all that apply.)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Constant Pain | <input type="checkbox"/> Unexplained Weight Loss/Gain | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Frequent/Painful Urination | <input type="checkbox"/> Excessive Bruising |
| <input type="checkbox"/> Fever, Chills, Sweats | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Severe Abdominal Pain | <input type="checkbox"/> Black/Bloody Stools | <input type="checkbox"/> Tightness in Chest |

Are you currently pregnant? No Yes, Due Date: _____

Have you ever had any of the following conditions?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Recurring Sinusitis | <input type="checkbox"/> Disc Herniation/Bulge |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Bloating | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Belching/Gas | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Swelling in Ankles/Legs | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Recurring Ear Infections | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Sprained Ankle |

Please list any injuries, hospitalizations or surgeries, with approximate dates: (broken bones, appendicitis, etc...)

Medications

Vitamins

Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dr.'s Notes

Lifestyle

Exercise

- None
- Minimal
- Moderate
- Daily
- Excessive

Work Activity

- Sitting
- Standing
- Light Labor
- Medium Labor
- Heavy Labor

Habits

- Smoking Frequency: _____
- Alcohol Frequency: _____
- Recreational Drugs Type: _____
- Coffee/Caffeine Frequency: _____
- High Stress Reason: _____

Nutrition

How would you describe your eating habits?

- I eat whatever and whenever I want.
- I make an attempt to eat right, but struggle.
- Most of the time I eat right, but treat myself on occasion.
- I strictly regulate my food intake, all the time.
- I'm all over the board. No consistency

Sleep

Average hours of sleep per night? _____

I normally sleep on my:

- Back
- Stomach
- Side
- Toss & Turn

Patient's Signature: _____

Receipt of Notice of Privacy Practices

I have been offered a copy of Barrows Chiropractic and Wellness Clinic Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand I can review this notice anytime at <https://barrowsclinic.com/hipaa-privacy-policy/> .

Initial: _____