

Bakke Chiropractic Clinic Patient Information Form

Clinic Use Only

___ New Injury Type: _____
___ PPN W/C _____ Dr: _____ Xray# _____ Chart# _____
___ React Auto _____ Clinic: _____
___ Update Oth: _____

Info Reviewed On: Date & Init: _____

PATIENT INFORMATION

Date: _____
Last Name: _____ First Name: _____ Mid Init: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Ph: _____ Cell #: _____ Work Ph#: _____ Ext: _____
Social Security # _____ Sex: ___M ___F Birth Date: _____ Marital: M S D W
****IF PATIENT IS A MINOR:** Responsible Party's Name: _____
If we need to contact you at home, what is the best time to call? ___ AM ___ PM ___ Evenings Time: _____
Employer: _____ Ph #: _____
Employers Address: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance** _____
Ins Name: _____ Ins Name: _____
Address: _____ Address: _____
State: _____ Zip: _____ State: _____ Zip: _____
****Subscribers Name:** _____ ****Subscribers Name:** _____
****Subscribers Birthdate:** _____ ****Subscribers Birthdate:** _____
Policy ID#: _____ **Group #** _____ **Policy ID#:** _____ **Group #** _____
Social Security #: _____ (if used as ID#) **Social Security #:** _____ (if used as ID#)

EMERGENCY

Spouse's Name: _____ Other Contact: _____
Spouse's Birthdate: _____ Relationship: _____
Employer: _____ Phone # _____ Phone#: _____ Cell#: _____

REFERRAL INFO

Please check all reasons you selected us for your care: Which is the primary reason? # _____
1. Previous Bakke Patient _____ 5. Newspaper _____ 9. Referred by family/friend (name) _____
2. Location _____ 6. Mailings _____ 10. Phone Book/Yellow Pages _____
3. Insurance Handbook _____ 7. Bakke Website _____ 11. Other: _____
4. Billboard _____ 8. Reputation of Clinic _____

Patient Signature: _____ **Date:** _____

Bakke Chiropractic Clinic

HEALTH HISTORY FORM

Name: _____ Date: _____ Case #: _____

Family Physician: _____ Date of last physical exam: _____

Sex: M F Height: _____ Weight: _____ Age: _____

✓ **Check the following conditions you have or have had:**
 ○ **Circle items that are common to other family members:**

- | | | | | |
|---------------------------------------|------------------------------------|--|---------------------------------|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | <input type="checkbox"/> Foot Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | | | <input type="checkbox"/> Tuberculosis |

Please check appropriate box for any of the following symptoms which you now have or have had previously.

<p style="text-align: center;"><u>GENERAL</u></p> <input type="checkbox"/> Allergy <input type="checkbox"/> Convulsions <input type="checkbox"/> Dizziness or Fainting <input type="checkbox"/> Headache <input type="checkbox"/> Nerve Problems <input type="checkbox"/> Numbness <p style="text-align: center;"><u>MUSCLE & JOINT</u></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Neck pain or stiffness <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Low back pain <input type="checkbox"/> Sciatica <input type="checkbox"/> Foot trouble <input type="checkbox"/> Swollen joints <p style="text-align: center;"><u>pain/numbness/cramps</u></p> <input type="checkbox"/> shoulders <input type="checkbox"/> hips <input type="checkbox"/> arms <input type="checkbox"/> legs <input type="checkbox"/> elbow <input type="checkbox"/> knees <input type="checkbox"/> hands <input type="checkbox"/> feet	<p style="text-align: center;"><u>GASTRO-INTESTINAL</u></p> <input type="checkbox"/> Difficult digestion <input type="checkbox"/> Distension of abdomen <input type="checkbox"/> Pain over stomach <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Colon trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <p style="text-align: center;"><u>EYES, EARS, NOSE & THROAT</u></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Colds <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus infection <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ear Noises/Ringing <input type="checkbox"/> Deafness <input type="checkbox"/> Eye conditions	<p style="text-align: center;"><u>CARDIO-VASCULAR</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Slow heart beat <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <p style="text-align: center;"><u>RESPIRATORY</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Spitting up blood	<p style="text-align: center;"><u>SKIN</u></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Skin eruptions/rash <p style="text-align: center;"><u>GENITO-URINARY</u></p> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Inability to control bladder <input type="checkbox"/> Kidney infection or stones <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Blood in urine <input type="checkbox"/> Bed-wetting
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HAVE YOU EVER:

- Had previous Chiropractic Care
- Been knocked unconscious
- Used a crutch or other support
- Been treated for a spine or nerve disorder
- Had a fractured bone
- Been hospitalized for other than surgery
- Ever had surgery (please list)

HABITS

- Alcohol
- Coffee
- Tobacco
- Drugs
- Other _____

List details: _____

Bakke Chiropractic Clinic
HEALTH HISTORY FORM

Name: _____ Date: _____ Case #: _____

List **ALL** medications you are presently taking: (include birth control pills and over the-the-counter meds):

Medication: _____ For what? _____

Medication: _____ For what? _____

Medication: _____ For what? _____

Medication: _____ For what? _____

FOR WOMEN ONLY

✓ **Check** the following conditions you have or have had;

Painful menstruation

Irregular cycle

Lumps in breast

Menopausal symptoms

Previous abnormal PAP

Using Birth Control

Date of last period: _____

Pregnant: Yes No

Previous miscarriages: Yes No

Please describe any other health problems or symptoms not covered: _____

PREGNANCY WARNING AND CONSENT TO XRAY

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that if there is a chance that I might be pregnant the 10 days following onset of a menstrual period are generally considered to be the safest time for an x-ray examination. With full understanding of the above, and believing that I am not currently at risk, I give the doctors of Bakke Chiropractic Clinic permission to perform an x-ray examination on me if they feel it is necessary.

Patient's Signature: _____ Date: _____

After reading and filling out the case history, your signature will verify that all the information you have given is accurate and that you have read the case history questions entirely.

Patient / Guardian Signature: _____

Date: _____

Bakke Chiropractic Clinic

PAIN DIAGRAM

Name _____ DOB: _____ Date: _____ Case # _____

Describe the **health problems** or **symptoms** that you **currently** have, and are seeking treatment for: _____

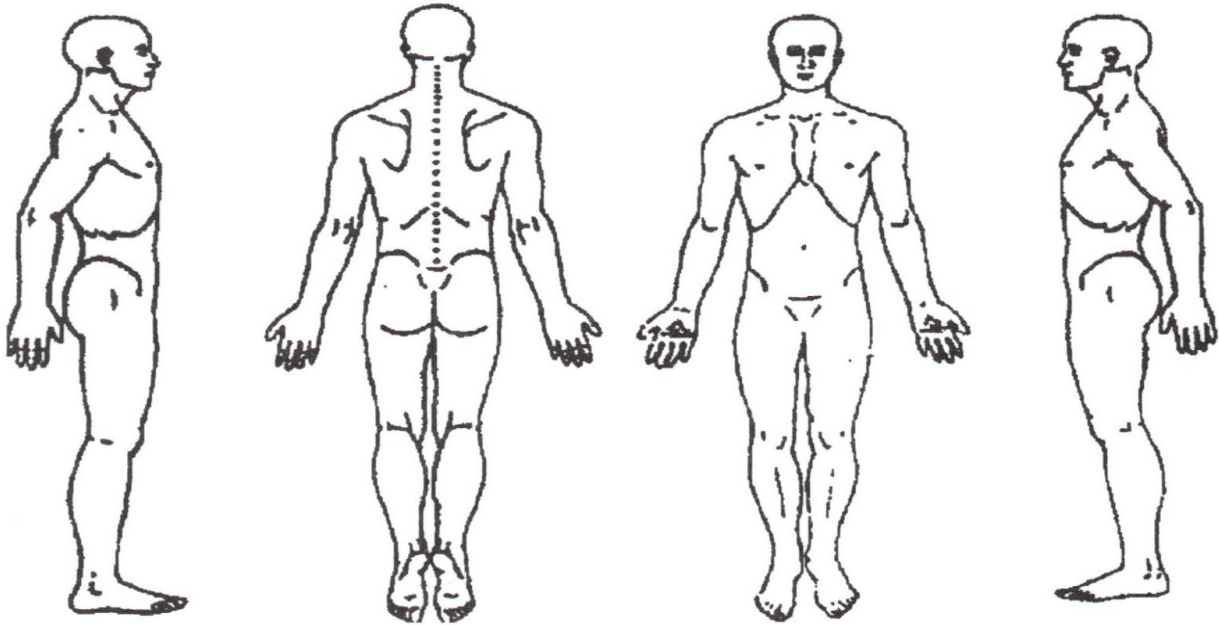
Date of symptom onset: _____ Describe what happened _____

Have these symptoms recently:

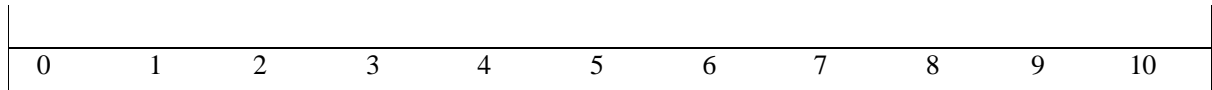
- become much worse
 become slowly worse
 remained about the same
 slowly improved
 greatly improved

MARK ON THE PICTURE WHERE YOU HAVE SYMPTOMS. PLEASE USE THE FOLLOWING SYMBOLS:

<u>Stiffness</u>	<u>Dull Pain or Aching</u>	<u>Sharp Pain</u>	<u>Burning</u>	<u>Numbness</u>	<u>Pins & Needles</u>
ssssss	oooooo	/////	xxxx	-----	++++++



On a scale of 0-10, with 0 meaning NO symptoms / can function normally, and 10 meaning very severe symptoms / can not function at all, where would you rate yourself overall. (Place an X on the line.)



NO SYMPTOMS

VERY SEVERE SYMPTOMS

Do you have **ANY** other health problems or symptoms that have not yet been covered today? Yes No

Please describe: _____

For Returning Patients Only

(For women only): Is there a chance that you might be pregnant? Yes No

Have you had any other health problems, surgeries, and/or broken bones since we last saw you? Yes No

Please explain: _____

List **All** medications you are presently taking, and for which conditions: (Include birth control pill and over-the-counter meds)

_____ For what? _____

_____ For what? _____

Patient's Signature: _____ Date: _____