GAINESVILLE BACK AND NECK PAIN RELIEF CHIROPRACTIC

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SHANNON W. BARGER, DC

CASE NO. _____

Please fill out the following form in as much detail as possible. ***(Please print)***

Name _____ Date_____
Address_____ Phone (____)_____
City_____ St.____ Zip_____ Alternate Phone(____)_____
E-mail Address_____
How did you hear about us? _____
Age____ Date of Birth___/____/____ Sex (M)___(F)___
Married (___) Single (___) # of Children_____ Name of Spouse_____
Have you ever had Chiropractic or Acupuncture care before? _____
For what problem? _____
Previous Chiropractor(s) or Acupuncturist(s) name / location: _____

PRESENT COMPLAINT

Major complaints and symptoms — please be as specific as you can.
1._____
2._____
3._____
4._____
How do you believe your problem (pain) began (cause)? _____
_____
_____
When did you first notice this problem/pain? _____
Have you ever had this condition before or a similar condition? _____
When? _____
What positions or activities aggravate your condition? _____
What positions or activities relieve your condition? _____

Have you ever been treated by a Medical Physician for this ailment? _____
Where? _____
Family physician's name _____
Have you been treated for any health condition by a physician in the past year?
If yes, what condition? _____
What prescription medication are you taking if any?
_____
_____
_____
_____

Past Health History

In the past have you experienced any of the following? When?

Surgery: _____
Hospitalization: _____
Infections: _____
Immunizations: _____
Trauma (accidents, falls): _____
_____
Allergies: _____

Family History

Do You or anyone in your Family have a history of any major illnesses? (Cancer, Stroke, Heart disease, Diabetes, Arthritis, etc.)

_____
_____
_____
_____

Occupational History

What do you do for a living? _____
Does your current condition affect your work? _____
Is your work the cause of your current condition? _____

Social History

DO YOU:
Smoke? Y or N
Drink Alcohol frequently? Y or N
Take Drugs? Y or N

HOW IS YOUR:
Diet? _____
Exercise? _____
Sleep? _____

Review of Systems

Are there any other issues going on that we haven't asked about- even if it seems unrelated?

_____
_____
_____

Date: _____ Patient Signature _____ CASE NO. _____

(Dr. Notes):

_____
_____
_____
_____
_____
_____
_____
_____