Bakke Chiropractic Clinic

PATIENT INFORMATION FORM

Clinic Use Only

____ New   Injury Type:
____ PPN   W/C _____   Dr: ___________   Xray#_______   Chart#_____________
____ React   Auto _____   Clinic: ___________
____ Update   Other _____

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

Email: ____

*****IF PATIENT IS A MINOR*****:** Responsible Party's Name: ____

Employer: ____ Ph #: __________________

Employers Address: ____

HEALTH INSURANCE INFORMATION

Primary Insurance:

Ins Name: ____________________________________

Address: _____________________________________

State: _______________________ Zip: ____________

****Subscribers Name:** ___________________________

****Subscribers Birthdate:** ________________________

Policy ID#: __________________ **Group #:** __________

Social Security #: _________________ (if used as ID#)

Secondary Insurance:

Ins Name: ____________________________________

Address: _____________________________________

State: ________________________ Zip: ___________

****Subscribers Name:** ___________________________

****Subscribers Birthdate:** ________________________

Policy ID#: __________________ **Group #:** __________

Social Security #: ________________ (if used as ID#)

EMERGENCY

Spouse's Name: _______________________________

Spouse's Birthdate: ____________________________

Employer: _______________ Phone #: ______________

Other Contact: _______________________________

Relationship: _________________________________

Phone#: _________________ Cell#: _________________

REFERRAL INFO

Please check all reasons you selected us for your care: Which is the primary reason? #_____

1. Previous Bakke Patient _____
2. Location _____
3. Insurance Handbook _____
4. Billboard _____
5. Newspaper _____
6. Mailings _____
7. Bakke Website _____
8. Reputation of Clinic _____
9. Referred by family/friend (name) _______________
10. Phone Book/Yellow Pages _____
11. Other: ______________________________

Patient Signature: ____ **Date:** ____________________

Bakke Chiropractic Clinic

HEALTH HISTORY FORM

Name: ______________________________ Date of Birth: ___________ Date: ___________ Case#__________

Race: ___________ Language: ___________ Ethnicity: Hispanic / Non-Hispanic

Family Physician: _________________________ Date of last physical exam: ______________

Sex: M F Weight: ______ Height: ____feet ____inches Age: _______

Mark the following conditions you or your family members have had.

	Self	Father	Mother	Brother	Sister		Self	Father	Mother	Brother	Sister
Medical Conditions											
Alcoholism						Foot Problems					
Anemia						Heart Disease					
Appendicitis						Miscarriage					
Cancer						Polio					
Diabetes						Stroke					
Eczema						Ulcers					
Emphysema						Multiple Sclerosis					
Goiter						Rheumatic Fever					
Gout						Tuberculosis					

Check the box for any of the following that you have currently or had recently.

General
- ☐ Allergy
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Nerve Problems
- ☐ Numbness
- ☐ Headache

Muscle/Joint
- ☐ Arthritis
- ☐ Neck pain/stiffness
- ☐ Mid-back pain
- ☐ Low back pain
- ☐ Sciatica
- ☐ Swollen joints

Gastro-Intestinal
- ☐ Distention/pain over stomach
- ☐ Gall Bladder trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

Eyes/Ears/Nose/Throat
- ☐ Asthma
- ☐ Colds
- ☐ Sinus Infection
- ☐ Nosebleeds
- ☐ Earache
- ☐ Ear Noises/Ringing
- ☐ Deafness
- ☐ Eye conditions

Cardio-Vascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Hardening of arteries
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting up phlegm
- ☐ Spitting up blood

Skin
- ☐ Bruises easily
- ☐ Dryness
- ☐ Skin eruptions
- ☐ Rash

Genito-Urinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Inability to control bladder
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Blood in urine
- ☐ Bed-wetting

HAVE YOU EVER:

☐Had 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: Use: ☐Rare ☐ Occasional ☐ Regular
☐Coffee
☐Smoking: ☐Previous ☐ Current ☐ Never
☐Smokeless tobacco
☐Illicit drugs

PLEASE TURN OVER AND COMPLETE OTHER SIDE -------→

Bakke Chiropractic Clinic

HEALTH HISTORY FORM

Case#__________

List ALL medications you are presently taking. Include birth control and over-the-counter medications:

Medication: ______________________________ For what? __________________________________

Medication: ______________________________ For what? __________________________________

Medication: ______________________________ For what? __________________________________

Medication: ______________________________ For what? __________________________________

Drug Allergies: ____

After reading and filling out this case history, your signature verifies that all information provided is accurate and that you have read the case history questions entirely.

Patient / Guardian Signature: ____________________________________ **Date**: _______________

THE FOLLOWING SECTION IS FOR WOMEN ONLY

Check the following conditions you have/have had:

○ Painful menstruation	○ Irregular cycle
○ Lump(s) in breast(s)	○ Menopausal symptoms
○ Previous abnormal PAP	○ Using Birth Control

Date of last period: ___________________________

☐Pregnant ☐Previous miscarriages

Please describe any other health problems or symptoms not already covered in this case history form:

____

____

____

PREGNANCY WARNING AND CONSENT TO X-RAY

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 I may be pregnant the 10 days following onset of 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 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: ____________________

____

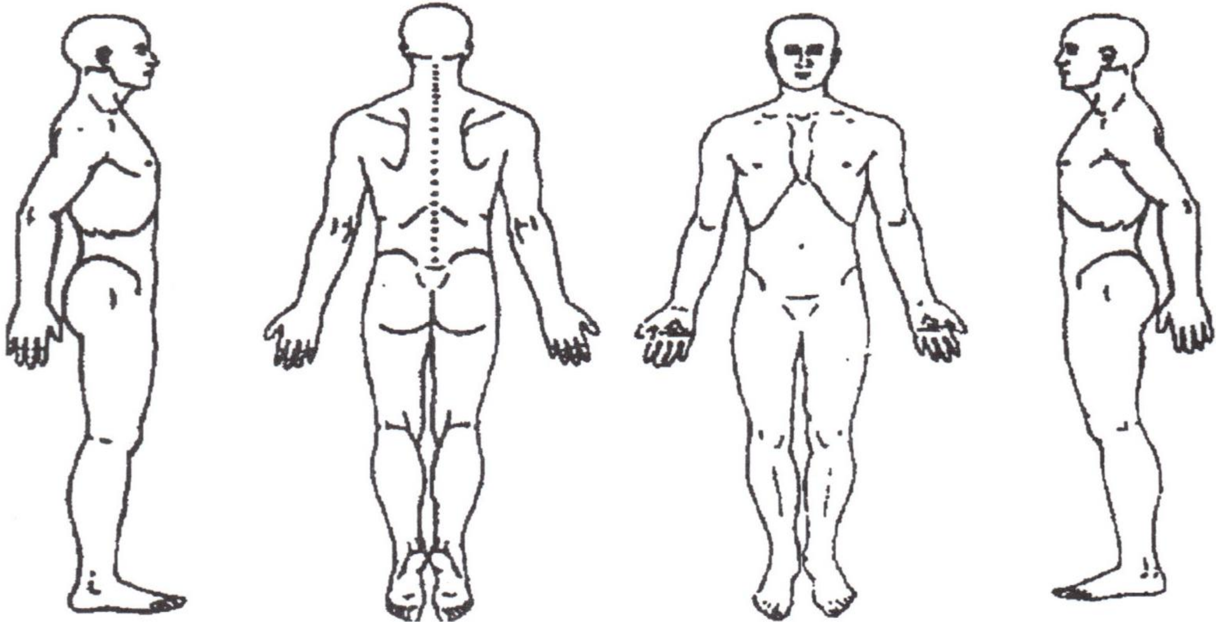
Date of symptom onset: __________________ Describe what happened: ____

Have these symptoms recently:

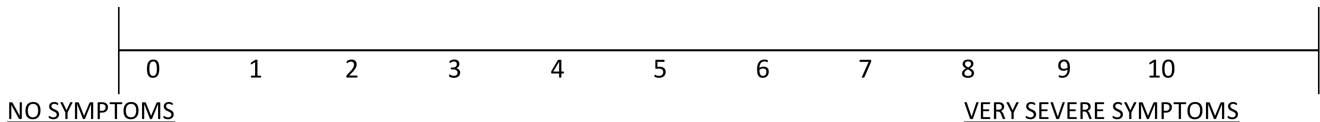
☐ become much worse ☐ become slowly worse ☐ remained about the same ☐ slowly improved ☐ greatly improved

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

Stiffness	Dull Pain or Aching	Sharp Pain	Burning	Numbness	Pins & Needles
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: ____

Patient's Signature: ______________________________________ Date: ______________________

For Returning Patients Only

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? ____

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