BARTLETT
PAIN & WELLNESS CENTER

Patient #:____________ **Today's Date:**________

Please allow our staff to photocopy your driver's license and insurance details.

All information you supply is confidential. We comply with all federal privacy standards.

Please print clearly.

Name:________________________________ **Date of Birth:**________________ **Gender:**__________

Address:______________________________ **City:**____________ **State:**______ **Zip Code:**_________

Email:___________________________ **Home Phone:**________________ **Cell Phone:**____________

Cell Carrier: ___________ **Would you like text message reminders regarding your appointments?:** YES NO

Work Number:________________ **Occupation:**_________________ **Employer:**________________

May we contact you at work?: YES NO **Preferred method of contact:**_________________________

Marital Status: Married Divorced Single Separated **Spouse's Name:**_____________________

How did you hear about us?:______________________ **Physician's Name:**________________________

Have you seen a chiropractor before?: YES NO **If yes, whom and when?:** _________________________

Race: O American Indian or Alaskan Native O Black or African American O Native Asian O Native Hawaiian O White O Other O Decline to Answer

Ethnicity: O British O Chinese O Irish O Hispanic or Latino O Non-Hispanic or Latino O Decline to Answer

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HISTORY

List any allergies:	List any surgeries and dates:	List any current medications:	List any major injuries:
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________

Tobacco	Alcohol	Caffeine	Drug use	Exercise
O Never Smoked	O None	O None	O Never	O Never
O Current Smoker (Daily)	O Casual Drinker	O Casual Drinker	O In the Past	O Daily
O Current Smoker (Weekly)	O Moderate Drinker	O Moderate Drinker	O Recreational Use	O Weekly
O Former Smoker	O Heavy Drinker	O Heavy Drinker	O Addiction	O Monthly

Current Condition

Primary Complaint: ____

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Secondary Complaint: ____

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Additional Complaint: ____

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How does you current condition effect:

Sitting	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Rising out of Chair	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Standing	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Walking	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Lying Down	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Bending Over	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Driving Car	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Sleeping	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect

Is your condition a result of accident or injury?

O Work O Auto O Other ______________________

Onset: (When did you first notice your symptoms?)

____

Prior interventions : (What have you done to relieve the symptoms?)

O Prescription medications
O Over-the-counter drugs
O Homeopathic remedies
O Physical therapy
O Surgery
O Acupuncture
O Chiropractic
O Massage
O Ice
O Heat
O Other____

How does you current condition interfere with your:

Work or career:____

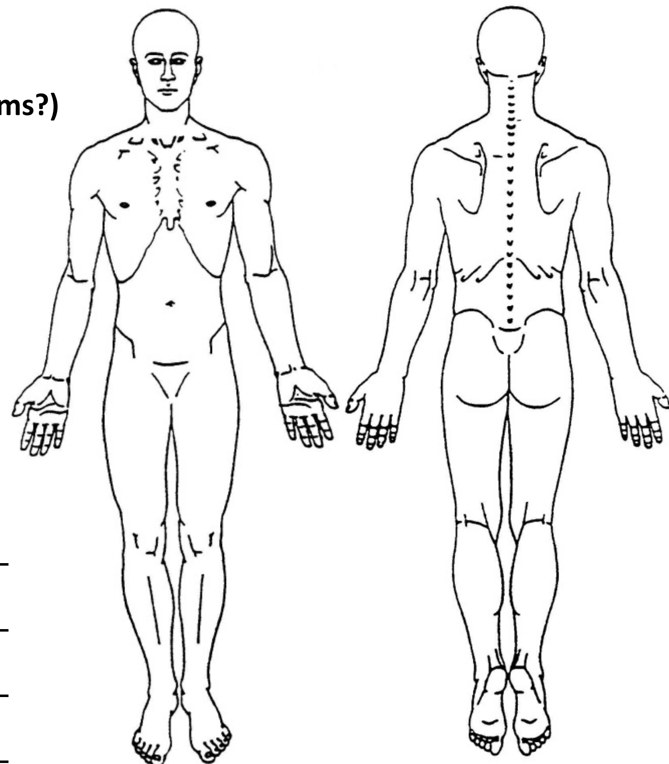
Recreational Activities:____

Household responsibility:____

Personal relationships:____

Mark your areas of complaint

(Pain = X Numbness/Tingling = O)



Review of Symptoms

Chiropractic care focuses on the health of you nervous system, which controls and regulates you whole body. Please indicate whether you've had or have any of the following conditions. Leave the space blank if the condition does not apply.

Have Had	Angina	Have Had	Anorexia/Bulimia	Have Had	Anxiety	Have Had	Apnea
Have Had	Arthritis	Have Had	Asthma	Have Had	Blurred Vision	Have Had	Chronic Ear Infection
Have Had	Constipation	Have Had	Depression	Have Had	Diabetes	Have Had	Diarrhea
Have Had	Dizziness	Have Had	Eczema	Have Had	Emphysema	Have Had	Erectile Dysfunction
Have Had	Excessive Bruising	Have Had	Fainting	Have Had	Fatigue	Have Had	Food Sensitivities
Have Had	Foot/Ankle Pain	Have Had	Frequent Infections	Have Had	Hair Loss	Have Had	Hay Fever
Have Had	Headache	Have Had	Hearing Loss	Have Had	Heartburn	Have Had	High Blood Pressure
Have Had	High Cholesterol	Have Had	Hip Disorder	Have Had	Hypoglycemia	Have Had	Immune Disorders
Have Had	Infertility	Have Had	Knee Injuries	Have Had	Kidney Stones	Have Had	Loss of Smell
Have Had	Loss of Taste	Have Had	Low Blood Pressure	Have Had	Low Energy	Have Had	Low Libido
Have Had	Neck Pain	Have Had	Numbness	Have Had	Osteoporosis	Have Had	Pins and Needles
Have Had	PMS Symptoms	Have Had	Pneumonia	Have Had	Poor Appetite	Have Had	Poor Circulation
Have Had	Poor Posture	Have Had	Prostate Issues	Have Had	Psoriasis	Have Had	Ringing in Ears
Have Had	Scoliosis	Have Had	Seizures/Epilepsy	Have Had	Shortness of Breath	Have Had	Shoulder Problems
Have Had	Skin Cancer	Have Had	Stroke	Have Had	Sudden Weight Loss/Gain	Have Had	Swollen Glands
Have Had	TMJ Issues	Have Had	Thyroid Issues	Have Had	Ulcer	Have Had	Weakness

Acknowledgements (Please Initial)

______I instruct the chiropractor to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

______I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf of seeking reimbursement from any involved third parties.

______I grant permission to be called or texted to confirm or reschedule any appointment and to be checked in on occasionally to track my progress.

______I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for any payment of covered or non-covered services that I receive.

______To the best of my ability, I have provided complete and truthful information.

Signature:____ Date_____________

Consent to Treat Minor:____ Date_____________