Barnes Wellness Center P.C.

Name:______________________________ Date:_________________________

MAJOR COMPLAINT:____

How long have you had this condition?_________________Date of Onset_______________

Have you lost workdays? YES / NO If yes, how many?_____________________

Have you had this similar condition before? YES NO If yes, when?___________________

Was the injury, accident related? NO / Auto accident / Work accident If yes, when?__________

What surgeries have you had? ____

____

List all drugs you now take (prescription and non prescription).________________________

____

Name other doctors you have seen for this condition:______________________________

Name of your primary care provider:____

Do you smoke? Y / N Drink Alcohol? Y / N Drinks per week? _____________

Family History of: ❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ Stroke

Anything else you would like to tell us that would help in determining your case? _______________

____

What are your health goals?____

How do you expect to achieve these goals?__________________________________

_____Fractured bones
_____Auto Accidents
____0-1 yrs ago
____1-5 yrs ago
____5 yrs or more
_____Other accidents, falls
_____Arthritis
_____Diabetes
_____Convulsions, epilepsy
_____Skin problems
_____Cancer
_____Frequent colds, flu
_____Depressed
_____Irritable
_____Anemia
_____Allergy, sinus
_____Under stress
_____Eating disorders
_____Trouble sleeping
_____Trouble concentrating
_____Learning disability
_____Mood Changes

_____Neck pain or stiffness R L
_____Numbness/tingling, pain in arms, hands, fingers R L
_____Jaw pain or clicks (TMJD) R L
_____Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
_____Shoulder pain R L
_____Dizziness
_____Ringing in ears R L
_____Hearing loss R L
_____Blurred or doubled vision
_____Upper back pain, stiffness
_____Mid back pain, stiffness
_____Lower back pain, stiffness
_____Pain with cough, sneeze
_____Hip pain R L
_____Headaches
_____Numbness, tingling, pain in buttocks, legs, feet, toes R L

_____Foot trouble R L
_____Chest pain, asthma
_____Heart problems
_____Stroke
_____High/low blood pressure
_____Varicose veins
_____Liver trouble
_____Gall bladder trouble
_____Digestive problems
_____Ulcers
_____Hemorrhoids
_____Prostate problems
_____Impotence
_____Kidney trouble
_____Menstrual problems (PMS)
_____Pregnant (NOW)
_____Bed wetting
_____Ear Infections
_____ AIDS, HIV

Barnes Wellness Center
PATIENT HISTORY

DATE________________________

NAME ____ DATE OF BIRTH_______________________

ADDRESS__________________________________CITY__________________STATE_____ZIP____________

PHONE (H)_________________PHONE (W)___________________ CELL PHONE:______________________

E-MAIL ADDRESS:_______________________________________ SOCIAL SECURITY #_________________

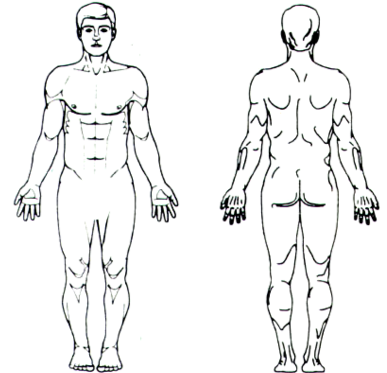
EMPLOYER________________________________OCCUPATION______________________________________

ADDRESS____

SPOUSE NAME____

NAME/PHONE OF PERSON TO CONTACT IN CASE OF EMERGENCY:_________________________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?________________________________



MAIN REASON FOR YOUR VISIT TODAY:

NECK PAIN HEADACHES MID-BACK

LOW BACK ARM SHOULDER LEG

OTHER_____________________________________

PAIN LEVEL: best 1 2 3 4 5 6 7 8 9 10 worst

(PLEASE MARK PAIN LOCATIONS ON THE DIAGRAM)

DATE OF ONSET:_______________

HOW DID THIS INJURY OCCUR?____

WHAT MAKES YOU FEEL BETTER__________________________***WORSE?***________________________

HAVE YOU HAD THIS PROBLEM BEFORE?_______***WHEN?***_____________________________________

WHAT DID YOU DO FOR THIS CONDITION BEFORE?____

Previous Chiropractic Care? Y / N Chiropractor's Name:_______________________________

DO YOU HAVE ANY OF THE FOLLOWING?

- ❑ HEADACHES
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DEPRESSION
- ❑ DIZZINESS
- ❑ MEMORY LOSS
- ❑ RINGING IN THE EARS
- ❑ DIGESTIVE PROBLEMS
- ❑ LIGHT SENSITIVITY
- ❑ STRESS OR ANXIETY
- ❑ NUMB HANDS OR FEET
- ❑ COLD HANDS OR FEET
- ❑ SHORTNESS OF BREATH
- ❑ DIFFICULTY SLEEPING
- ❑ LOSS OF SMELL OR TASTE

How will you be paying for your first visit services today?

❑ ***Cash*** ❑ ***Check*** ❑ ***Credit Card*** ❑ ***PI*** ❑ ***Work Comp***

SIGNATURE____

(Please have your insurance card available for us to photocopy)