

BERTELSMAN **CHIROPRACTIC**

INFORMATION UPDATE

Please update any information that has changed since your last visit to our office.

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Home phone _____
Employer _____ Work phone _____
Emergency contact _____ Relationship _____ Phone _____
E-Mail Address _____ Cell phone _____
Family physician _____ Date of last physical _____

Current condition information

When did your condition begin? _____

Is your condition due to an Automobile Accident? Yes No

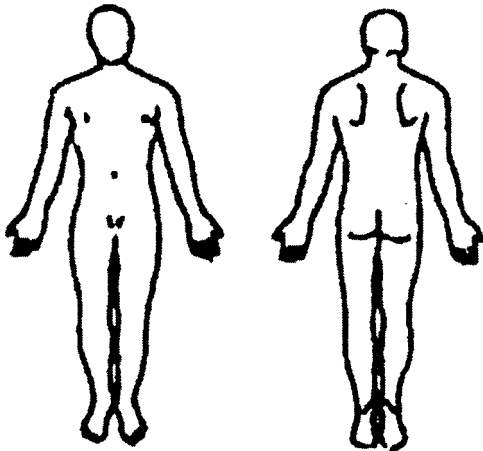
Is your condition due to an Employment Related Injury? Yes No If so, have you reported it? Yes No

Days lost from work _____ Other Doctors seen for this condition _____

Have you had the same or similar symptoms before? Yes No Approx. Date of prior condition _____

May we forward our findings to your family physician? Yes No

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity

(1) _____
(2) _____
(3) _____

Are you currently taking any medications? _____

Previous surgeries _____

Do you have a personal history of Cancer Diabetes Heart Disease Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tingling Legs | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Numbness in hands | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> Pain unrelieved by rest |

For women: Are you pregnant? Yes No

Are you taking birth control? Yes No