Welcome to Berklich Chiropractic Center

Thank you for providing us with the following general information so that we may serve you better

Date: _____ Whom may we thank for referring you to us: _____

Patient Demographics

Patient Name: _____ DOB: _____ Sex: ☐ M/ ☐ F

What would you prefer to be called? _____ SSN: _____

Marital Status: ☐ Married ☐ Single ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired

Primary Language: _____ Religion: _____

Sexual Orientation: _____ Gender Identity: _____

Ethnicity: _____ Race: _____

Mother's Maiden Name: _____

Advance Directive Type: ☐ No Advance Directive ☐ Living Will ☐ Durable Power of Attorney ☐ Do Not Resuscitate

Provider Information

Referring Doctor: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Patient Contact Information

Address: _____

City *State* *Zip*

Home Phone: _____Cell Phone: _____ Work Phone: _____

E-mail: _____ Communication Preference: _____

Employment Information

Employer Name: _____ Employer Phone: _____

Address: _____

City *State* *Zip*

Emergency Contact Information

Contact Name: _____ Relationship to Patient: _____

Contact Address: _____

City *State* *Zip*

Home Phone: _____Cell Phone: _____ Work Phone: _____

Next of Kin

Contact Name: _____ Relationship to Patient: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Insurance Information

Primary Insurance Name: _____

Policy Holder Name: _____ Relationship to Patient: _____

Member/Subscriber ID: _____ Group #: _____

Secondary Insurance Name *(if applicable)*: _____

Policy Holder Name: _____ Relationship to Patient: _____

Member/Subscriber ID: _____ Group #: _____

Insurance Benefits Assigned to the Provider

I hereby authorize assignment of my insurance rights and benefits directly to the provider of services rendered, Berklich Chiropractic Center.

Patient Signature: _____ Date: _____

Signature: _____ Relationship to Patient: _____

(Parent/Legal Guardian/Person having legal custody)

Berklich Chiropractic Center

Patient Health Questionnaire

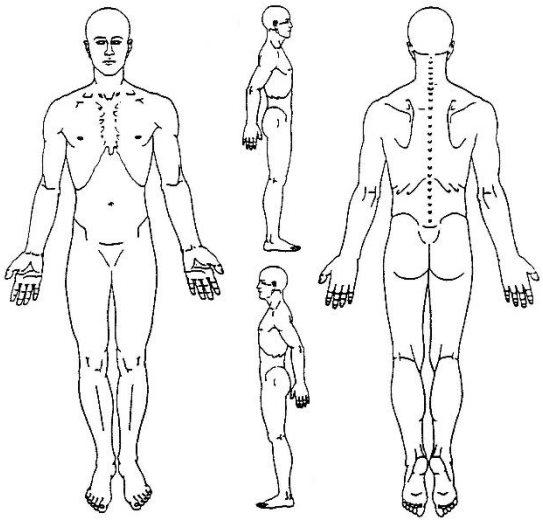
Patient Name: _____ Date: _____

1. When did your symptoms start? _____
2. Describe your symptoms and how they began: _____

_____

3. Are your symptoms the result of an injury, fall, accident? ☐ Yes ☐ No
4. How often do you experience your symptoms?
   a) ☐ Constantly (75-100% of the day)
   b) ☐ Frequently (51-75% of the day)
   c) ☐ Occasionally (26-50% of the day)
   d) ☐ Intermittently (0-25% of the day)

Please indicate where you have pain or other symptoms.



5. Describe the nature of your symptoms.
   a) ☐ Burning
   b) ☐ Dull ache
   c) ☐ Numb
   d) ☐ Sharp
   e) ☐ Shooting
   f) ☐ Tingling
6. How are your symptoms changing?
   a) ☐ Getting better
   b) ☐ Not changing
   c) ☐ Getting worse
7. During the *past 4 weeks* including both work outside the home and housework:
   a) Indicate the average intensity of your symptoms.
      ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

   b) How do your symptoms affect your ability to perform daily activities?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Complaints	Mild, forgotten with activity	Moderate, interferes with activity	Limiting, prevents full activity	Intense, preoccupied with seeking relief	Severe, no activity possible

8. What activities make your symptoms worse?

_____

9. What activities make your symptoms better?

_____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

11. What tests have you had for your symptoms?

☐ X-rays date: _____ ☐ MRI date: _____ ☐ CT Scan date: _____ ☐ Other date: _____

12. Who have your seen for your symptoms? ☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ PT ☐ Other

13. In the past 90 days, have you had (please check yes or no):
   a) Any loss of appetite ☐ Yes ☐ No
   b) Dizziness, Lightheartedness, or Fainting: ☐ Yes ☐ No
   c) Fevers, Chills, or Night Sweats: ☐ Yes ☐ No
   d) General Fatigue: ☐ Yes ☐ No
   e) Weight gain/loss of 10 pounds or more ☐ Yes ☐ No

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Patient Health Questionnaire

If you have ever had a symptom in the past listed below, check that symptom in the past column. If you are presently troubled by a particular symptom, check that symptom in the present column. This is a history of various systems of your body and knowledge of these conditions may influence the type of treatment, therapy, or referral you may receive.

Past	Present	Condition	Past	Present	Condition
☐	☐	Abdominal Pain	☐	☐	Heartburn/Indigestion
☐	☐	Angina	☐	☐	Hepatitis
☐	☐	Anorexia	☐	☐	High Blood Pressure
☐	☐	Aortic Aneurysm	☐	☐	Irritable Colon
☐	☐	Arthritis	☐	☐	Jaw Pain
☐	☐	Bladder Infections	☐	☐	Loss of Bladder Control
☐	☐	Blood Disorder	☐	☐	Low Back Pain
☐	☐	Breast Soreness/Lump	☐	☐	Mid Back Pain
☐	☐	Cancer, Explain: _____	☐	☐	Muscular Incoordination
☐	☐	Chest Pains	☐	☐	Neck Pain
☐	☐	Chronic Cough	☐	☐	Pain in Ankle or Foot
☐	☐	Colitis	☐	☐	Pain in Lower Leg or Knee
☐	☐	Constipation/Irregular Bowel Habits	☐	☐	Pain in Upper Arm or Elbow
☐	☐	Convulsions	☐	☐	Pain in Upper Leg or Hip
☐	☐	Diabetes	☐	☐	Painful Urination
☐	☐	Depression	☐	☐	PMS
☐	☐	Dermatitis/Eczema/Rash	☐	☐	Profuse Menstrual Flow
☐	☐	Difficulty in Swallowing	☐	☐	Prostate Problems
☐	☐	Dizziness	☐	☐	Rapid Heartbeat
☐	☐	Emphysema (Chronic Lung Disorder)	☐	☐	Rheumatoid Arthritis
☐	☐	Endometriosis	☐	☐	Scoliosis
☐	☐	Epilepsy	☐	☐	Shoulder Pain
☐	☐	Excessive Thirst	☐	☐	Stroke, Date: _____
☐	☐	Fainting	☐	☐	Swelling/Stiffness of Joints
☐	☐	Frequent Urination	☐	☐	Tinnitus (Ear Noises)
☐	☐	General Fatigue	☐	☐	Tumor, Explain: _____
☐	☐	Hand Pain (☐ Right, ☐ Left)	☐	☐	Ulcer
☐	☐	Headache	☐	☐	Visual Disturbances
☐	☐	Heart Attack, Date: _____	☐	☐	Wrist Pain

Family History: if any of your immediate family members have/had the following, please mark the appropriate line.

	Mother	Father	Brother(s)	Sister(s)
Cancer	☐	☐	☐	☐
Cardiovascular Disease:	☐	☐	☐	☐
Chronic Back Problems	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐
Kidney Failure:	☐	☐	☐	☐
Retinal Detachment:	☐	☐	☐	☐
Rheumatoid Arthritis/Lupus	☐	☐	☐	☐

Have you ever had surgery or been hospitalized? ☐ No ☐ Yes, Describe: _____

What medications are you currently taking? _____

_____

Smoking History: ☐ Former Smoker ☐ Never Smoked ☐ Smoker, Frequency: _____

Do you drink alcohol? ☐ No ☐ Yes, Frequency: _____

Do you have or have had an alcohol, drug, or any other kind of addiction or dependence? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

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Auto Related Accident Information

1. Date and Time of the Accident: Date: _____ Time: _____ ☐ AM or ☐ PM
2. Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Right Rear Seat Passenger ☐ Left Rear Seat Passenger
3. Were you using the seat belt/shoulder harness? ☐ Yes ☐ No
4. Were you stopped at the time of the accident? ☐ Yes ☐ No
5. Did your vehicle sustain visible damage? ☐ Yes ☐ No
6. Where did your vehicle sustain damage? ☐ Front ☐ Back ☐ Right Side ☐ Left Side
7. Did the airbags inflate because of this accident? ☐ Yes ☐ No
8. Was there anyone else in the car with you? ☐ Yes ☐ No

8.1 Were they injured? ☐ Yes ☐ No

9. Do you recall any part of your body striking anything inside the vehicle? ☐ Yes ☐ No

9.1 If yes, describe the body part struck and what it struck:

_____

10. Were you surprised or aware the accident was about to happen? ☐ Surprised ☐ Aware
11. If you recall, where you were looking at the time of impact, please describe:
    ☐ Looking forward ☐ To my left side ☐ To my right side ☐ Other, explain:
    _____
12. In your own words, please describe how the accident happened:

_____

_____

13. Did EMT's come to the scene of the accident? ☐ Yes ☐ No
14. Were you treated at the scene of the accident? ☐ Yes ☐ No
15. Were you transported to a medical facility/hospital by EMT's? ☐ No ☐ if Yes, Name of the medical facility/hospital: _____
16. Did you or someone else take you to a medical facility/hospital from the scene of the accident? ☐ No ☐ if Yes, Name of the medical facility/hospital: _____
17. As a result of this accident, have you been evaluated or treated in any health care facilities or by any healthcare providers? ☐ No ☐ if Yes, Name of the medical facility/hospital: _____
18. What symptoms did you experience immediately following the accident? _____
19. What symptoms did you have within the next several hours? _____
20. What symptoms did you have the next morning? _____
21. Since the accident, what new symptoms or conditions have developed and when did you begin to notice these symptoms? _____
22. Since the accident, what symptoms or conditions, that you may have had prior to the accident, seem to have worsened?
    _____
23. Draw a brief sketch of the roads and where the cars/objects made impact. Label your car as "**ME"**