BEARD CHIROPRACTIC FAMILY WELLNESS CLINIC

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CONFIDENTIAL PATIENT INFORMATION

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Today's Date: ______________________ Name: ____ ☐M ☐F

Date of Birth: ________________ Phone: ______________________ Cell Phone: ____________________________

Address: ______________________________________ City: ________________ State: _________ Zip: _________

E-mail ______________________________________ Social Security #: ______________________________

Marital Status: ☐M ☐S ☐D ☐W

Number of Minor Children _____ Names/Ages ____

Your Employer: ________________________________

Employers Address: ______________________________

__________________ Work Phone: ________________

Occupation: ________________ Yrs Employed: ________

Spouse: ________________ Date of Birth: ____________

Employer: ____

Employer's Address: ________________________________

____

Person Responsible for this account_________________________________ referred by: __________________________

PAYMENT INFORMATION:

☐**I Have Insurance.**

I authorize direct payment of medical benefits, from my insurance company, to Danny R. Beard, D.C. or supplier for any services performed in his office. I also authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party that accepts assignment.

It is understood that all reasonable efforts will be made to collect from my insurance company before I will be responsible for this I do understand that any and all amounts which are not collectable from my insurance company shall become my responsibility and I agree to pay those charges within 30 days. I further agree that any insurance reimbursement check received by me which funds is owed to Dr. Beard shall be transferred to Dr. Beard in full amount within 10 days of my receipt of the check.

If I owe a deductible or co-payment for my treatment, I agree that I shall make all reasonable efforts to pay for that at the time of service. If that is not possible I shall discuss the matter with the office staff.

☐**I Will be Paying Cash/Check/Credit Card.**

Due to my circumstances, I will be receiving a discounted fee which is less than the usual and customary charge for chiropractic care in Dr. Beard's office. In order to keep in compliance with Wisconsin's insurance laws, this "Prompt Payment Discount" must be paid on the same day the services are rendered and no insurance will be billed. Any services not paid for on the same day will have to be charged our normal rates. Exceptions will only be made in emergency situations, with prior notification to our office.

☐**I have read/received the "Notice of Privacy Policy" and agree to its terms.**

Signature: ____ Date: ______________________

Witness: ____ Date: ______________________

PLEASE DESCRIBE PRESENT MAJOR COMPLAINT (Worst problem first):

1. ___________________________________ Worse in: ☐AM ☐PM Pain: ☐Is Constant ☐Comes & Goes
2. ___________________________________ Worse in: ☐AM ☐PM Pain: ☐Is Constant ☐Comes & Goes
3. ___________________________________ Worse in: ☐AM ☐PM Pain: ☐Is Constant ☐Comes & Goes
4. ___________________________________ Worse in: ☐AM ☐PM Pain: ☐Is Constant ☐Comes & Goes

Symptoms developed from?
☐ Job related injury ☐ Auto accident ☐Other Injury ☐Illness ☐ Gradual onset ☐ Unknown
Date occurred: _________________How occurred:____
Have had symptoms for #_____Hr(s) ___Day(s) ___Wk(s) ___Mo(s) ___ Yr(s)
Have you ever had this before: ☐ No ☐Yes When?___________
What do you do that makes this problem worse? ____
Name and location of doctors previously seen for present conditions(s): _____________________________
Were x-rays or scans done? Y N Date: ____________ Location: ________________________________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:
☐ Bending ☐ Sitting ☐Reaching ☐Standing ☐Turning Head ☐Lifting ☐ Walking ☐Lying Down
☐Straining at Stool ☐Coughing ☐Sneezing ☐_______________ ☐_______________ ☐______________

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
☐Bending ☐Sitting ☐Standing ☐ Lying Down ☐ Turning Head ☐Walking ☐Chiropractic Adjustments
☐Ice ☐Heat ☐__________________ ☐___________________ ☐___________________

PLEASE CHECK ALL CURRENT SYMPTOMS:

NECK:
☐Neck Pain
☐Muscle Spasms
☐Pinched Nerve
☐Grinding

GENERAL:
☐Confusion
☐Irritable
☐Depressed
☐Fatigue
☐Loss of Weight
☐Weight Gain
☐Diabetes
☐Hypoglycemia

HEAD:
☐Headache
☐Migraine
☐Feels Heavy
☐Memory Loss
☐Fainting
☐Dizziness
☐Vision Trouble
☐Ringing Ears

CHEST:
☐Chest Pain
☐Short of Breath
☐Rib Pain
☐Breast Pain

MID-BACK:
☐Mid-back Pain
☐Pn b/w Shlder Blades
☐Sharp Stabbing
☐Dull Ache
☐Muscle Spasms

SHOULDERS:
☐Pain
☐Can't Raise Arm
☐Shoulder Ht.
☐Over Head
☐Bursitis

LOW BACK:
☐Low Back Pain
☐Muscle Spasms

ABDOMEN:
☐Nausea
☐Gas
☐Diarrhea
☐Constipation

MEN ONLY:
☐Urinary Pain
☐ Frequent Urination
☐Difficulty Starting
☐Night Urination

HIPS/LEGS/FEET:
☐Buttocks Pain (R-L)
☐Hip Joint Pain
☐Knee Pain
☐Leg/Feet Symptoms:
☐Pain
☐Pins & Needles
☐Numbness
☐Cramps
☐Cold Feet
☐Swollen Ankles

ARMS/HANDS:
☐Arm Pain
☐Elbow Pain
☐Wrist Pain
☐Hand Pain
☐Pins & Needles
☐Numbness
☐Cold Hands
☐Swollen Hands

WOMEN ONLY:
☐Menstrual Pain
☐Cramps/Irregular
☐Birth Control
☐Menopause

MEDICAL / FAMILY HISTORY S=Self M=Mother F=Father (Please indicate which conditions have been experienced)

	S	M	F		S	M	F		S	M	F		S	M	F
AIDS………………..	☐	☐	☐	Convulsions………...	☐	☐	☐	HIV / ARC…………	☐	☐	☐	Poor Circulation…..	☐	☐	☐
Anemia……………...	☐	☐	☐	Diabetes…………….	☐	☐	☐	Kidney Disorder…...	☐	☐	☐	Hepatitis…………..	☐	☐	☐
Arthritis……………..	☐	☐	☐	Indigestion…………	☐	☐	☐	Bowel Control Loss..	☐	☐	☐	Rheumatic Fever…	☐	☐	☐
Asthma……………...	☐	☐	☐	Dislocated Joints……	☐	☐	☐	Menstrual Cramps…	☐	☐	☐	Rheumatism………...	☐	☐	☐
Back Pain…………...	☐	☐	☐	Epilepsy…………….	☐	☐	☐	Multiple Sclerosis….	☐	☐	☐	Scarlet Fever………..	☐	☐	☐
Bladder Trouble…….	☐	☐	☐	German Measles……	☐	☐	☐	Muscular Dystrophy.	☐	☐	☐	Serious Injury……….	☐	☐	☐
Bone Fracture………	☐	☐	☐	Headaches………….	☐	☐	☐	Neck Pain…………	☐	☐	☐	Sinus Trouble……….	☐	☐	☐
Cancer………………	☐	☐	☐	Heart Trouble………	☐	☐	☐	Nervousness………	☐	☐	☐	Tuberculosis…………	☐	☐	☐
Chest Pain…………..	☐	☐	☐	Reproductive Disord.	☐	☐	☐	Numbness…………	☐	☐	☐	Venereal Disease…….	☐	☐	☐
Concussion…………	☐	☐	☐	High Blood Pressure	☐	☐	☐	Polio………………	☐	☐	☐	Fibromyalgia………..	☐	☐	☐

PREVIOUS HISTORY:

Have you been treated by a physician for any health condition in the past year? ☐No ☐Yes
Describe Condition:____ Date of Last Physical Exam__________________

SURGICAL HISTORY: 1. ____ Date: _________________
2. ____ Date:_________________
3. ____ Date: _________________

ACCIDENT HISTORY: ☐Job ☐Auto ☐Other ___________________________ Date:_________________
☐Job ☐Auto ☐Other ___________________________ Date:_________________
☐Job ☐Auto ☐Other ___________________________ Date: _________________

LIFESTYLE INFORMATION:

Will you be healthier 5 years from now than you are today? Y N Not Sure

Have you had previous chiropractic care? Y N If yes, what was the doctor's name? ________________________

What was the date of your last visit? ______________ Were x-rays or scans done? Y N Date: _________________

Females: Is there any chance you are pregnant? Y N Date last menstrual period ended?______________________

Do you take vitamins/supplements? Y N If yes, please list ____

Do you have any skin conditions/disorders? Y N ____

Do you consume alcohol? Y N If yes, how many drinks per week?_____________

How many glasses of water do you drink per day? ______ How many times do you exercise per week? ________

Do you have problems with digestion or elimination? Y N

What activities do you enjoy? ____

What is the length and quality of your sleep? _____hrs/night I sleep: easily restlessly

Is there anything else you would like the doctor to know about your health or your lifestyle?

____

Please circle the letter(s) of the items that apply to you. If unsure leave blank.
Occurred or occurring during: C=Childhood T=Teen years A=Adulthood N=Not at all

Physical Stress		Emotional Stress		Chemical Stress	
Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip / Fall	C T A N	Career	C T A N	Smoker	C T A N
Posture	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Car Accident	C T A N	Money	C T A N	Caffeine	C T A N
Sports Injury	C T A N	Fast Paced Life	C T A N	Artificial Sweeteners	C T A N
Physical Abuse	C T A N	Hold in Feelings	C T A N	Prescription Drugs	C T A N
Work Injury	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on Wallet	C T A N	Perfectionist	C T A N	Self Medicate	C T A N
Stomach Sleeper	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Computer Work	C T A N	Loss of Loved One	C T A N	Alcohol	C T A N
Repetitive Lift/Bending	C T A N				
Prolonged Driving	C T A N				
Prolonged Standing	C T A N				
Prolonged Sitting	C T A N				
Surgery/Broken Bones	C T A N				
Lack of Phys. Activity	C T A N				
Excess Phys. Activity	C T A N				

What do you feel is the primary stressor in your life?_________________________

Rate (circle) your combined overall level of stress from all sources listed above.

No Stress---1---2---3---4---5---6---7---8---9---10---High Stress