

Date _____ Bergman Family Chiropractic Account# _____

Name _____ Address _____

City/State/Zip _____

How were you referred to our office? _____

Primary Phone _____ Secondary Phone _____

Social Security # _____ Date Of Birth _____

Are You Married? Y/N Do You Have Children? Y/N Are They Currently Under Care Here? Y/N

Emergency Contact _____ Phone # _____

Relationship To Emergency Contact _____

E-mail Address _____ Would You Like To Receive Our Health News Letter Y/N

Reason For Today's Visit: New Injury Old Injury Chronic Pain Wellness Visit

Are You In Pain? Y/N Discomfort 1 2 3 4 5 6 7 8 9 10 Intense (Please Circle One)

Did your injury occur during: Work Sports/ play Auto Accident Routine/ Household activity

When did your condition/ accident occur? _____/_____/_____ Where did your injury occur?

Please explain what happened:

Is your condition getting worse? Yes No Constant Comes and goes

Is your condition interfering with your: Work Sleep or Daily routine? If so, how:

Has this or something similar happened in the past?

Yes No Explain: _____

Using the adjacent body charts, please circle all affected Areas.

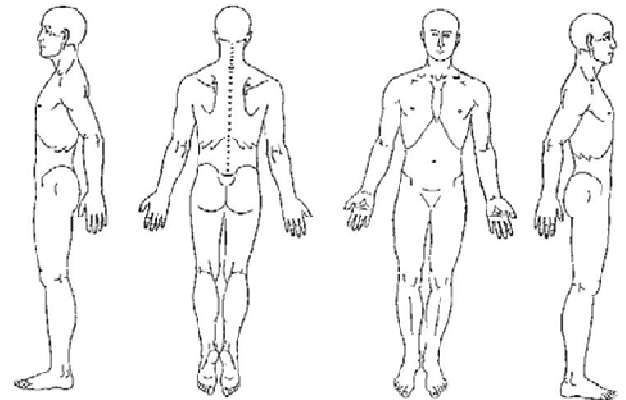
Have you been treated by a medical physician for this

Pain? Yes No If so, where? _____

Have you ever been treated by a chiropractor? Yes No

Clinic or Dr's Name: _____

Clinic Phone#: _____



Left

Back

Front

Right

Are you taking any of the following medications? Nerve Pills Pain killers (including aspirin) Muscle relaxes Blood Thinners Tranquilizers Insulin Other(s)

Is there anything else that you want to ask the Doctor ? _____