

**PATIENT INFORMATION**

Date \_\_\_\_\_

SS/HIC/Patient ID \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name , First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Gender  M  F Age \_\_\_\_\_

Birth date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Ideal Weight \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered

Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birth date \_\_\_\_\_

SS# \_\_\_\_\_

Whom may we thank for Referring you? \_\_\_\_\_

**INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group# \_\_\_\_\_

Is patient covered by additional insurance  Yes  No

Subscriber's name \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co \_\_\_\_\_

Group# \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly \_\_\_\_\_  
(Name of Insurance Company)

to Dr. Ekberg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above mentioned doctor may use health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal representative

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to patient

**PHONE NUMBERS**

Home ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** \_\_\_\_\_

Relationship \_\_\_\_\_

Home ( \_\_\_\_\_ ) \_\_\_\_\_ Work( \_\_\_\_\_ ) \_\_\_\_\_

**ACCIDENT INFORMATION**

Is condition due to an accident  Yes  No

Date of Accident \_\_\_\_\_

Type of Accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

**PATIENT CONDITION**

Reason for visit/Chief Complaint \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Not Sure

Mark an X on the picture where you continue to have pain, numbness or tingling. \_\_\_\_\_ →

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10 (circle one)

Type:  Pain  Numbness  Swelling  Spasm  Tightness  Stiffness  Tingling  Weakness

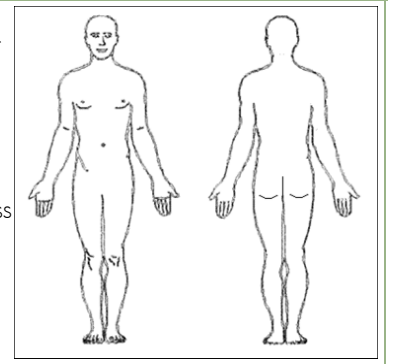
Quality:  Sharp  Dull  Aching  Throbbing  Crushing  Stabbing  Burning

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go?  Constant  Frequent  Comes and goes  Occasional

Does it interfere with or cause pain during:  Walking  Sitting  Bending  Standing

Sleeping  Lifting  Driving  Bending over  Doing Computer Work  Sitting to Standing  Recreation/Sports



## PATIENT CONDITION #2 (IF APPLICABLE)

Additional problem. \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Not Sure

Mark an X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10 (circle one)

Type:  Pain  Numbness  Swelling  Spasm  Tightness  Stiffness  Tingling  Weakness

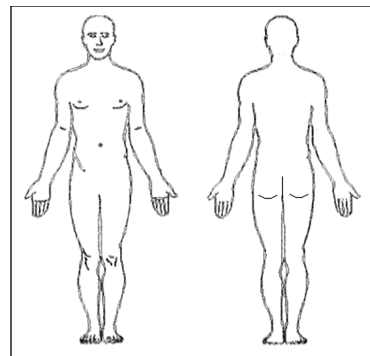
Quality:  Sharp  Dull  Aching  Throbbing  Crushing  Stabbing  Burning

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go?  Constant  Frequent  Comes and goes  Occasional

Does it interfere with or cause pain during:  Walking  Sitting  Bending  Standing

Sleeping  Lifting  Driving  Bending over  Doing Computer Work  Sitting to Standing  Recreation/Sports



## HEALTH HISTORY

What treatments have you already received for your condition?  Medication  Surgery  Physical Therapy  
 Chiropractic  None  Other \_\_\_\_\_

Name and address of other doctor who have treated you for this \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Other procedure or test \_\_\_\_\_

Medications Taken: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Trans-	
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	mitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

To your knowledge have you ever had long term exposure to chemicals, pesticides, herbicides, radiation, solvents or heavy metals?

No  Yes If Yes, explain \_\_\_\_\_

Do you currently have or have you previously had metal filling in your teeth  Yes  No

## MENSTRUAL HISTORY (WOMEN ONLY—OBVIOUSLY)

Date of last menstrual period \_\_\_\_\_ Age of first onset \_\_\_\_\_ Are you currently pregnant  Yes  No

Are your periods regular?  Yes  No If No, Explain \_\_\_\_\_

Do you experience cramping?  No  Slight  Moderate  Severe

Other PMS symptoms  No  Yes Explain \_\_\_\_\_

Are you using birth control pills?  No  Yes Did you ever?  No  Yes What kind \_\_\_\_\_

## LIFESTYLE

How often do you have a bowel movement?

\_\_\_\_\_ X/day     every other day    \_\_\_\_\_ X/wk

**Habits**     Diet Soda    Cans/day \_\_\_\_\_     None  
 Artificial Sweetener    Specify \_\_\_\_\_     None  
 Margarine    Specify \_\_\_\_\_     None

## HEALTH GOALS - WHY ARE YOU HERE?

Which of the following most closely describes your goal for your care in this office?

- I'm interested in pain relief only. I'm only interested in pursuing care until my symptoms are gone.
- I will continue care for the number of visits allowed by insurance and hope the symptoms are gone by then.
- I'm primarily interested in symptom relief, but I'm open to learning what else is possible.
- I want the best health and wellbeing possible. I understand that health is far more than symptom relief. I am prepared to take an active part in my care plan and I want to learn all I can about health.

How committed are you to taking care of your health. Please circle one.

10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

If it is recommended, or determined to be beneficial, would you be willing to/interested in:

- Modify your dietary habits?     Yes     No
- Take Supplements?     Yes     No
- Engage in exercise?     Yes     No
- Read Books?     Yes     No

Dr Ekberg is very passionate about the long term health of his patients. You will therefore be provided by e-mail a free health newsletter containing news and articles written by Dr. Ekberg as well as professional chiropractic staff writers. Dr. Ekberg also conducts work shops for a more in depth look at health and body function. Please keep a look out for invitations by email, times and dates.

## CONSENT TO CARE

I understand that Dr. Sten Ekberg does not diagnose or treat any medical conditions; that the purpose of chiropractic care is to allow the body to heal naturally by removing or reducing the factors that interfere with healing. I hereby give Dr. Ekberg permission to treat me with chiropractic adjustments and any non-invasive modality he deems appropriate. I may always ask about the purpose and performance of any procedure and elect not to have it done.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Dr's Notes

O \_\_\_\_\_  
P \_\_\_\_\_  
P \_\_\_\_\_  
Q \_\_\_\_\_  
R \_\_\_\_\_  
S \_\_\_\_\_  
T \_\_\_\_\_  
\_\_\_\_\_