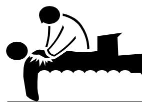


HALBERG CHIROPRACTIC CLINIC

430 E. Lauridsen Blvd. Port Angeles, WA 98362 Phone (360) 457-7576

Date____/____/____

CONFIDENTIAL INFORMATION

James Halberg, D.C.

PATIENT INFORMATION:

Full Name:______________________ Date of Birth: _____/_____/_______ SS# ______ - _____ - ________

Address: ______________________ City ______________ St. _____ Zip ________ Phone ____________

Email: ______________________Occupation: ______________ Employer's Name: ________________

Work Address: ______________________ City ______________ St. _____ Zip ________ work Phone ____________

Marital Status: (circle one) **Single** **Married** **Other** Emergency Contact ____________________ Phone ____________

Who referred you to our clinic?__________ Name of medical doctor? ___________ May we contact your medical doctor? _____

INSURANCE INFORMATION: (circle one) **Medicare** **Auto Accident** **Work Injury** **Other Insurance** **Cash**

What is your **Main Complaint** today?____

How **long** have you had this current episode of pain?____________ Has it been getting **better** or **worse** or the **same** since it started?

Cause of symptoms: ______________________ Have you had the **same** or **similar** before? (circle one) **Yes** **No**

How **often** are complaints present? (circle one) **Constant** (75—100%) **Frequent** (50—74%) **Intermittent** (25—49%) **Occasional** (less than 25%)

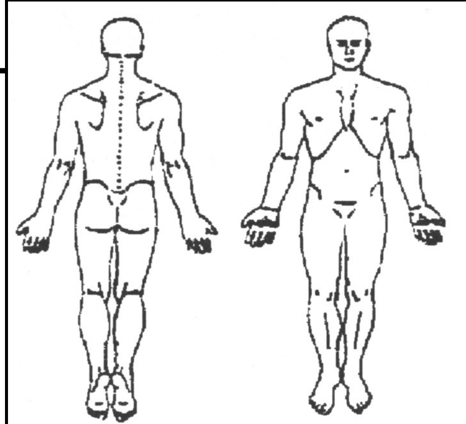
What **Helps it?** ______________________ What **Hurts it?** ______________________

PAIN SCALE

Please circle the number that best describes the level of your pain today

1	2	3	4	5	6	7	8	9	10
NONE		LITTLE		MEDIUM		MEDIUM SEVERE			SEVERE

Mark areas of **P**ain, **B**urning, **N**umb, **T**ingling



Describe your past health history: (If you need more room, please write on the back)

Prior Illness: ______________________________________

Past Hospitalizations: ______________________________________

Surgeries: ______________________________________

Do you have a family history of **Stroke**, **Heart Disease**, or **Cancer**?______________

Do you smoke?________ Drink alcoholic beverages?________ How often?_________

Date of last physical exam: ___/___/___ Are you currently under a doctor's care? ____ If yes, please explain: ________________

Please indicate if you currently have or have ever had any of the following conditions:

_____ heart disease
_____ menstrual pain/irregularities
_____ irregular heart beat
_____ high blood pressure
_____ bowel changes/problems
_____ peripheral vascular disease
_____ light-headedness or fainting
_____ high cholesterol
_____ joint pain
_____ diabetes
_____ eating disorder
_____ loss of sensation
_____ cancer
_____ thyroid disease
_____ headaches
_____ lung disease
_____ chest pain
_____ anemia
_____ stroke
_____ asthma
_____ sexual dysfunction
_____ arthritis
_____ kidney disease
_____ obesity
_____ gallbladder disease
_____ wt loss/gain
_____ ulcers
_____ back pain

Medications (taking now) : Prescription ______________________ Over-the-counter ______________________

Nutritional supplements (taking now) : ______________________________________

I give Halberg Chiropractic Clinic and its representatives permission to communicate to me via the contact information above.

Patient Signature: X ______________________________________