Nathan L. Barkalow D.C.

Chiropractic
HEALTH & WELLNESS CENTER

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Patient Information

Todays Date: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female ❑ Declined to Specify SSN: _____

First Name: _____ Middle Name: _____ Last Name: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Immediate Family Seen by CHWC: _____

Emergency Contact: _____

Relation: _____ Phone: _____

Referred By: _____

Employer Information

Occupation: _____ Status: ❑ Full-Time ❑ Part-Time ❑ Student ❑ Homemaker ❑ Retired ❑ Unemployed

Employer or School: _____ Phone: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Carrier: _____ Phone: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Sex: ❑ M ❑ F Date of Birth: _____

Policy Holder Address: _____

City: _____ State: _____ Zip: _____

Relation to Patient: _____ Phone: _____

Primary Care

Primary Care Physician: _____ Phone: _____

Clinic Name / Location: _____

Last Visit Date: _____ X-ray, CT, or MRI: ❑ Yes ❑ No OK to Request Records? ❑ Yes ❑ No

Patient Health History Questionnaire

PATIENT NAME: _____ **DOB**:_____

*List all **Prescription**, **Over-the-Counter medications**, and **Nutritional/Herbal supplements** you are taking:*

_____ _____ _____

_____ _____ _____

*List any **Medication Allergies**:*_____ _____

*List any **Surgical Procedures** you have had and times you have been **hospitalized**:*

_____ _____ _____

_____ _____ _____

What type of regular exercise do you perform? ❑ None ❑ Light ❑ Moderate ❑ Strenuous

What is your height and weight? Height _____ Weight _____ lbs.

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past.
If you presently have a condition listed below, place a check in the PRESENT column.

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	High Blood Pressure	❑	❑	Diabetes
❑	❑	Neck Pain	❑	❑	Heart Attack	❑	❑	Excessive Thirst
❑	❑	Upper Back Pain	❑	❑	Chest Pains	❑	❑	Frequent Urination
❑	❑	Mid Back Pain	❑	❑	Stroke	❑	❑	Drug Alcohol Dependence
❑	❑	Low Back Pain	❑	❑	Angina	❑	❑	Smoking/Nicotine Products
❑	❑	Shoulder pain	❑	❑	Kidney Stones	❑	❑	Allergies
❑	❑	Elbow/Upper Arm Pain	❑	❑	Kidney Disorders	❑	❑	Depression
❑	❑	Wrist pain	❑	❑	Bladder Infection	❑	❑	Systemic Lupus
❑	❑	Hand Pain	❑	❑	Painful Urination	❑	❑	Epilepsy
❑	❑	Hip/Upper Leg pain	❑	❑	Loss of Bladder Control	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Knee/Lower Leg Pain	❑	❑	Prostate Problems	❑	❑	HIV/AIDS
❑	❑	Ankle/Foot Pain	❑	❑	Abnormal Weight Gain/Loss	❑	❑	SARS Covid 19
❑	❑	Jaw Pain	❑	❑	Loss of Appetite	❑	❑	Chronic Sinusitis
❑	❑	Joint Swelling/Stiffness	❑	❑	Abdominal Pain	❑	❑	Scoliosis _____
❑	❑	Arthritis	❑	❑	Ulcer	❑	❑	Other_____
❑	❑	Rheumatoid Arthritis	❑	❑	Hepatitis			
❑	❑	General Fatigue	❑	❑	Liver/Gall Bladder Disorder			***Females Only***
❑	❑	Muscular Incoordination	❑	❑	Cancer	❑	❑	Birth Control Pills
❑	❑	Visual Disturbances	❑	❑	Tumor	❑	❑	Hormonal Replacement
❑	❑	Dizziness	❑	❑	Asthma	❑	❑	Pregnancy

Patient Social

Homemade Food	❑Daily	❑Weekly	❑Occasionally	❑Never	**Caffeine**	❑Daily	❑Weekly	❑Occasionally	❑Never
Processed Food	❑Daily	❑Weekly	❑Occasionally	❑Never	**Drugs**	❑Daily	❑Weekly	❑Occasionally	❑Never
Diet Food	❑Daily	❑Weekly	❑Occasionally	❑Never	**Stimulants**	❑Daily	❑Weekly	❑Occasionally	❑Never
Soft Drinks	❑Daily	❑Weekly	❑Occasionally	❑Never	**Alcohol**	❑Daily	❑Weekly	❑Occasionally	❑Never
Water	❑Daily	❑Weekly	❑Occasionally	❑Never	**Tobacco**	❑Daily	❑Weekly	❑Occasionally	❑Never
Exercise	❑Daily	❑Weekly	❑Occasionally	❑Never					

Smoking: ❑ Everyday Smoker ❑ Occasional Smoker ❑ Former Smoker ❑ Never Smoked

Race: ❑ American Indian or Alaska Native ❑ Black or African American ❑ Asian
❑ White (Caucasian) ❑ Native Hawaiian or Pacific Islander ❑ Declined to Answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to Answer

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

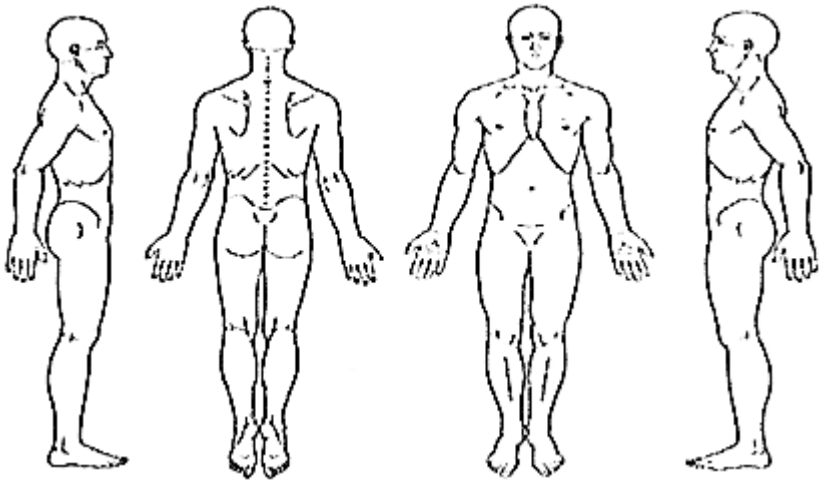
1. **When did your symptoms start?** _____
2. **Describe your symptoms and how they began:** _____

_____

_____

3. **How often do you experience your symptoms?**
   - ❑ Constantly (76-100% of the day)
   - ❑ Frequently (51-75% of the day)
   - ❑ Occasionally (26-50% of the day)
   - ❑ Intermittently (0-25% of the day)

Indicate below where you have pain or other symptoms:



4. **What describes the nature of your symptoms?**
   - ❑ Sharp ❑ Shooting
   - ❑ Dull ache ❑ Burning
   - ❑ Numb ❑ Tingling
   - ❑ Other _____
5. **How are your symptoms changing?**
   - ❑ Getting Better
   - ❑ Not Changing
   - ❑ Getting Worse
6. **How bad are your symptoms at the:**

	none										*unbearable*
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

7. **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. **Who have you seen for your symptoms?** ❑ Medical Doctor ❑ Physical Therapist ❑ No One ❑ Other Chiropractor ❑ Other _____
    - *a. What type of treatment and when?* _____ *date*: _____
    - *b. What tests have you had for you symptoms and when were they performed?* ❑ Xrays *date*: _____ ❑ CT Scan *date*: _____ ❑ MRI *date*: _____ ❑ Other *date*: _____
11. **Have you had similar symptoms in the past?** ❑ Yes ❑ No
    - *a. If you have received treatment in the past for the same or similar symptoms, who did you see?* ❑ Medical Doctor ❑ Physical Therapist ❑ This Office ❑ Other Chiropractor ❑ Other _____
12. **Your daily activity consists of** *(work and/or home)*: ❑ No activity ❑ Sitting ❑ Standing ❑ Walking ❑ Lifting ❑ Bending ❑ Running ❑ Driving
13. **What do you hope to get from your visit/treatment** *(select all that apply)*:
    - ❑ Reduce symptoms ❑ Resume/increase activity ❑ Explanation of condition/treatment
    - ❑ How to prevent this from occurring again ❑ Learn how to take care of this on my own

Patient Signature: _____ **Date:** _____