BARKER **CHIROPRACTIC**
Helping Families THRIVE & Kids BE Kids
9308 Carlton Hills Blvd. Santee, CA 92071
Phone: (619) 449-1601

CONFIDENTIAL PATIENT INFORMATION

How did you hear about us?

☐ BARKER **CHIROPRACTIC** Employee ☐ Health Care Provider ☐ Other: _____
☐ Newspaper ☐ Internet/Website ☐ Health Fair ☐ Patient: _____

Full Name (First, Middle, Last): _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Preferred contact method: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: M / F Height: _____ Weight: _____

Marital Status: S / M / D / W Spouse's Name: _____ # of Children: _____

Occupation: _____ Business/Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

☐ I hereby give permission to release information related to my care to my family physician.

Emergency Contact: _____ Phone: _____

INITIAL PROBLEM RECORD

What is your main complaint or problem?

How did this begin?

When did this begin?

Has this happened before? If yes, when?

What makes your problem better?

What makes your problem worse?

Since the problem began, it has: □ Improved □ Worsened □ Not changed

This problem bothers me: □ Occasionally (0 - 25% of the time) □ Intermittently (25 - 50% of the time)
□ Frequently (50 - 75% of the time) □ Constantly (75 - 100% of the time)

Do you have any other related or unrelated complaints you would like to address?

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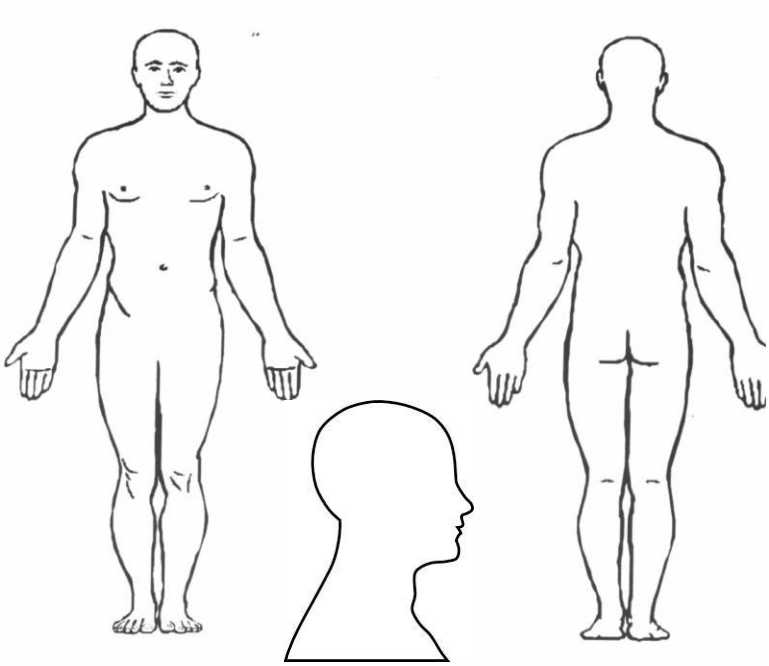
Have you ever suffered from:

- □ Alcoholism
- □ Anemia
- □ Arteriosclerosis
- □ Arthritis
- □ Asthma
- □ Back Pain
- □ Breast Lump
- □ Bronchitis
- □ Bruise Easily
- □ Cancer
- □ Chest Pain/Conditions
- □ Cold Extremities
- □ Constipation
- □ Cramps
- □ Depression
- □ Diabetes
- □ Digestion Problems
- □ Dizziness
- □ Ears Ringing
- □ Excessive Menstruation
- □ Eye Pain or Difficulties
- □ Fatigue
- □ Frequent Urination
- □ Headache
- □ Hemorrhoids
- □ High Blood Pressure
- □ Hot Flashes
- □ Irregular Heart Beat
- □ Irregular Cycle
- □ Kidney Infection/Stones
- □ Loss of memory
- □ Loss of balance
- □ Loss of smell
- □ Loss of taste
- □ Neck Pain or Stiffness
- □ Nervousness
- □ Nosebleeds
- □ Pacemaker
- □ Polio
- □ Poor Posture
- □ Prostate Trouble
- □ Sciatica
- □ Shortness of breath
- □ Sinus Infection
- □ Sleep Problems or Insomnia
- □ Spinal Curvatures
- □ Stroke
- □ Swelling of Ankles
- □ Swollen Joints
- □ Thyroid Condition
- □ Tuberculosis
- □ Ulcers
- □ Varicose Veins
- □ Venereal Disease
- □ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing



DID YOU KNOW…?

◯ Doctors of Chiropractic work with the nervous system?
□ **YES** □ **NO**

◯ The nervous system controls all bodily functions and systems?
□ **YES** □ **NO**

Have any immediate or secondary family members ever been diagnosed with:			**Family member(s) diagnosed:**
Cancer	yes	no	
Diabetes	yes	no	
High Blood Pressure	yes	no	
Heart Disease	yes	no	
Stroke	yes	no	
Arthritis	yes	no	
Seizures	yes	no	

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Please list any:	Date(s):	Comments:
Surgeries (including minor and cosmetic)		
Hospitalizations		
Pregnancies & births		
Significant traumas (concussions, auto accidents, falls, etc.)		
Allergies (drugs, foods, chemicals)		
Medications (prescription and over-the-counter) taken within the past two months		
Vitamins, supplements, herbs taken within the past two months		

Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee/Caffeine	◯	◯	◯	◯
Tobacco Products	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Stress	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty foods	◯	◯	◯	◯
Sugary foods	◯	◯	◯	◯
Artificial sweeteners	◯	◯	◯	◯
Vitamins/Supplements	◯	◯	◯	◯

I understand that all services rendered are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of these benefits. I clearly understand that all services rendered to be are charged directly to me and I am responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional service rendered to me will be immediately due and payable.

Signature: _____ Date: _____