

3441 Arden Way, Sacramento 95825

(916) 485-6434

www.barhamchiropractic.com

PERSONAL INFORMATION

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

CELL PHONE _____ EMAIL _____

SSN _____ DATE OF BIRTH _____ AGE _____

HEIGHT _____ WEIGHT _____ MALE FEMALE SINGLE MARRIED DIVORCED #CHILDREN _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ WORK PHONE _____

NAME OF SPOUSE (OR PARENT) _____

MEDICAL INFORMATION

FAMILY PHYSICIAN: _____ WHERE ARE THEY LOCATED? _____

HAVE YOU EVER HAD CHIROPRACTIC CARE? IF YES, DOCTOR NAME _____

DATE OF LAST VISIT _____

IF YOU ARE EXPERIENCING ANY PAIN (NECK PAIN, MID BACK PAIN, LOW BACK PAIN, ETC.) HEALTH PROBLEMS,

SYMPTOMS, AND/OR COMPLAINTS, PLEASE LIST IN ORDER OF SEVERITY:

1. _____ FOR HOW LONG? _____

2. _____ FOR HOW LONG? _____

3. _____ FOR HOW LONG? _____

4. _____ FOR HOW LONG? _____

HAS THIS PROBLEM BEEN GETTING WORSE STAYING THE SAME

HAVE YOU EVER EXPERIENCED ANY OF THESE COMPLAINTS WHILE WORKING? YES NO

IF YES, PLEASE DESCRIBE WHAT ACTIVITIES MAY BE CAUSING THESE COMPLAINTS:

ARE THERE ANY OTHER ACTIVITIES, INCIDENTS, OR EVENTS OUTSIDE WORK THAT MAY HAVE CAUSED THESE COMPLAINTS? IF YES, EXPLAIN:

HAVE YOU AT ANY TIME IN THE PAST SUFFERED A WORK INJURY? IF YES, EXPLAIN:

DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR THIS WORK INJURY? YES NO

IF YES, WHO IS YOUR ATTORNEY? _____

HAVE YOU BEEN INVOLVED IN AN AUTO ACCIDENT IN THE LAST 12 MONTHS? YES NO

IF YES, DATE OF THE AUTO ACCIDENT _____

DO YOU HAVE AN ATTORNEY REPRESENTING YOU FOR THIS AUTO ACCIDENT? YES NO

IF YES, WHO IS YOUR ATTORNEY? _____

HOW MANY PASSANGERS WERE IN THE CAR WITH YOU? _____

LIST DOCTORS CONSULTED FOR THESE CONDITIONS: 1. _____ 2. _____

IF DUE TO AN ACCIDENT, WHO IS YOUR AUTO INSURANCE COMPANY? _____

MEDICAL HISTORY

HAVE YOU EVER HAD ANY SURGERIES OR HOSPITALIZATIONS? YES NO

IF YES, PLEASE LIST: _____

PLEASE LIST ANY CURRENT OR PAST INJURIES AND ILLNESSES NOT LISTED ABOVE:

PLEASE CHECK ALL MEDICATIONS (OVER THE COUNTER AND/OR PRESCRIBED) YOU ARE CURRENTLY TAKING: ASPIRIN
 TYLENOL PAIN KILLERS MUSCLE RELAXERS INSULIN BIRTH CONTROL PILLS SLEEPING PILLS
 ANTI-DEPRESSANTS OTHERS _____

INSURANCE INFORMATION

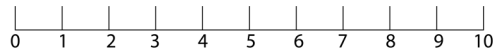
HEALTH INSURANCE COMPANY NAME _____ POLICY HOLDER _____

CLAIM ADDRESS _____

POLICY NUMBER _____

SECONDARY INSURANCE /SPOUSE INSURANCE (IF DIFFERENT FROM ABOVE): _____

FOR EACH OF THE SIX CATEGORIES OF DAILY LIVING LISTED, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** 0 MEANS NO DISABILITY AT ALL, AND A SCORE OF 10 MEANS THAT ALL OF THE ACTIVITIES IN WHICH YOU WOULD NORMALLY BE INVOLVED HAVE BEEN TOTALLY DISRUPTED OR PREVENTED BY YOUR HEALTH CONDITION (AOM AND/OR SYMPTOMS)



1. **FAMILY/HOME RESPONSIBILITIES:** ACTIVITIES RELATED TO THE HOME OR FAMILY INCLUDING CHORES AND DUTIES PERFORMED AROUND THE HOUSE (YARD WORK, DOING CHORES, ERRANDS, FAVORS FOR OTHER FAMILY MEMBERS, DRIVING CHILDREN TO SCHOOL, ETC.) _____

2. **RECREATION:** HOBBIES, SPORTS, AND OTHER SIMILAR LEISURE TIME ACTIVITIES _____

3. **SOCIAL ACTIVITY:** ACTIVITIES WHICH INVOLVE PARTICIPATION WITH FRIENDS AND AQUAINTANCES OTHER THAN FAMILY MEMBERS INCLUDING PARTIES, THEATRE, CONCERTS, DINING OUT, AND OTHER SOCIAL FUNCTIONS _____

4. **OCCUPATION:** ACTIVITIES THAT ARE A PART OF OR DIRECTLY RELATED TO ONE'S JOB INCLUDING NONPAYING JOBS AS WELL, SUCH AS HOMEMAKER OR VOLUNTEER WORKER _____

5. **SELF CARE:** ACTIVITIES WHICH INVOLVE PERSONAL MAINTENANCE AND INDEPENDENT DAILY LIVING (TAKING A SHOWER, DRIVING, GETTING DRESSED, ETC.) _____

6. **LIFE SUPPORT ACTIVITIES:** BASIC LIFE SUPPORTING BEHAVIORS SUCH AS EATING, SLEEPING, AND BREATHING _____

METHOD OF PAYMENT FOR TODAY'S CHARGES CASH CHECK CREDIT CARD _____

NOTICE: NOT ALL PATIENT'S REQUIRE X-RAYS TO FETERMINE TYPE PF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED
2. THE FEE PAID FOR X-RAYS IS FOR ANALYSIS ONLY. WE ARE REQUIRED TO MAINTAIN YOUR ORIGINAL X-RAYS. FILMS MAY BE LOANED TO ANOTHER HEALTH PROVIDER WITH YOUR PRIOR AUTHORIZATION ONLY.

PATIENT SIGNATURE _____ DATE _____

PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN. FOR EXAMPLE: DULL, SHARP, CONSTANT, OFF AND ON, WHEN STANDING, SITTING, WORKING, ETC.

COMPLETE THESE DIAGRAMS

