NEW PATIENT FORM
ADULT

Barge Berkley Chiropractic Clinics
La Crosse 608 784-4639
Holmen 608 781-9777

PATIENT INFORMATION

Name _____ Today's Date _____ Referred by _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Birthday _____ Age _____ Gender ☐ M ☐F Are you pregnant? ☐ No ☐ Yes
Significant Other's Name _____ Kid's Names and Ages _____
Your Employer _____ Occupation _____
e-Mail Address _____ Have you been to a chiropractor before? ☐No ☐Yes
Emergency Contact _____ Relation _____ Phone _____
Name of Medical Doctor _____ Phone _____

- I authorize the doctors and staff of Barge Chiropractic to render care as deemed appropriate for me.
- I authorize Barge Chiropractic to release and request records to or from other providers as may be necessary.
- I authorize Barge Chiropractic to release all necessary information to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me.
- I understand I am responsible for all bills incurred in this office.
- I understand Barge Chiropractic follows HIPAA compliance guidelines.

Patient Signature _____ Date _____
(This represents a long term authorization for all occasions of service.)

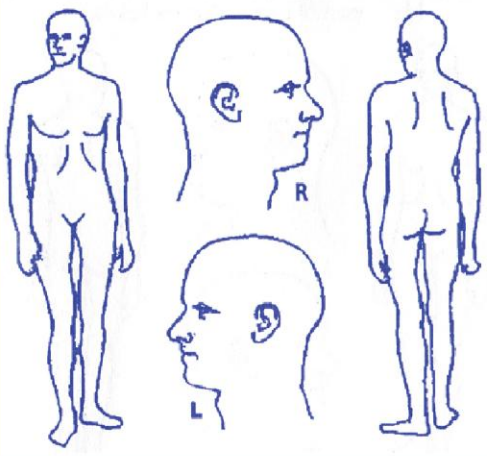
REASON FOR SEEKING CARE

What is the purpose of your visit? ☐ Preventative Wellness ☐ Complaint ☐ Auto Accident Injury ☐ Work Injury

Main Complaint _____
When did this begin? _____
Describe: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb/Tingly
Pain radiates to _____
☐ Constant ☐ Frequent ☐ Occasional
Rate pain from 0 to 10 (0 = no pain, 10 = disabling) _____
Is the pain: ☐ Staying the same ☐ Getting worse ☐ Getting better
☐ Worse in the morning ☐ Worse in the evening
What makes it worse? _____
What makes it better? _____
Does your condition affect: ☐ Sleeping ☐ Working ☐ Walking
☐ Sitting ☐ Driving ☐ Standing ☐ Your Daily Routine
What Doctor(s) have you seen for this? _____
If you were feeling 100% healthy what could you do that you cannot currently do? _____
_____

Additional Health Concerns _____
_____
Explain _____
_____

Please mark all areas of concern



HEALTH HISTORY

Patient Name _____ *Please mark the conditions that apply to you.*

GENERAL

Past	Current	
☐	☐	Chronic Fatigue
☐	☐	Tobacco Use
☐	☐	Alcohol Use
☐	☐	Cancer
☐	☐	Dizziness

NEUROLOGICAL

Past	Current	
☐	☐	Ringing in the ears
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Arthritis
☐	☐	Leg/Foot Numbness
☐	☐	Seizures

MUSCULOSKELETAL

Past	Current	
☐	☐	Muscle Aches
☐	☐	Trouble Walking
☐	☐	Joint Stiffness
☐	☐	Muscle Weakness
☐	☐	Osteoporosis
☐	☐	Joint Replacement

MENTAL HEALTH

Past	Present	
☐	☐	Anxiety
☐	☐	Depression

RESPIRATORY

Past	Current	
☐	☐	Shortness of breath
☐	☐	Asthma
☐	☐	Pneumonia
☐	☐	Emphysema

GASTRO-INTESTINAL

Past	Current	
☐	☐	Diarrhea
☐	☐	Chron's Disease
☐	☐	Digestive Problems
☐	☐	Acid Reflux
☐	☐	Constipation
☐	☐	Gallbladder Problems
☐	☐	Liver Problems

ENDOCRINE

Past	Present	
☐	☐	Hot Flashes
☐	☐	Hair Loss
☐	☐	Type I Diabetes
☐	☐	Type II Diabetes
☐	☐	Menstrual Problems
☐	☐	Hypothyroidism
☐	☐	Hyperthyroidism

EYES, EARS, NOSE, THROAT

Past	Current	
☐	☐	Allergies
☐	☐	Throat Problems
☐	☐	Ear Problems
☐	☐	Nose Problems
☐	☐	Eye Problems

GENITO-URINARY

Past	Current	
☐	☐	Urinary Problems
☐	☐	Kidney Problems
☐	☐	Kidney Stones
☐	☐	Bed Wetting
☐	☐	Prostate Problems

CARDIOVASCULAR

Past	Current	
☐	☐	Easy Bruising
☐	☐	Poor Circulation
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Heart Disease
☐	☐	Heart Attack
☐	☐	High Cholesterol
☐	☐	Stroke
☐	☐	Pacemaker

Other: _____

List any medications you are currently taking: _____

List all Doctors you are currently seeing: _____

PAST HISTORY

List any past auto accidents: _____ Was any care received? _____

List any past work injuries: _____ Was any care received? _____

List any past sport, recreational or home injuries: _____

Describe any past conditions and treatment received: _____

List any past hospitalizations and surgeries: _____

FAMILY HEALTH HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_____

Is there any other family history we should know about? _____

_____