BARISCH
Family Chiropractic

TODAY'S DATE: ____________________
REFERRED BY: ____________________

CONFIDENTIAL MEMBER INFORMATION

Name: ____________________ Date of Birth: ____________________ Marital Status: ____________
Address: ____________________ Phone Number: ____________________
City: ____________________ Employer: ____________________
State: ________ Zip: __________ Occupation: ____________________
Email: ____________________ Preferred Contact Method (Text, Call, E-Mail): ____________________

AS A RESULT OF MY CHIROPRACTIC CARE I WOULD LIKE TO:

- ☐ Feel better quickly
- ☐ Have a healthier spine
- ☐ Have a healthier body
- ☐ Reach a higher health status
- ☐ Recover from injury/illness
- ☐ Restore Joint Function

YOUR HEALTH HISTORY (0-17 Years)

AS A YOUTH, DID YOU EVER:

Receive Chiropractic Care?	Y ☐ N ☐	____________________
Fall out of bed as an infant?	Y ☐ N ☐	____________________
Fall down steps, out of a tree or off bike?	Y ☐ N ☐	____________________
Have any other falls or accidents?	Y ☐ N ☐	____________________
Recurrent childhood illness/sickness?	Y ☐ N ☐	____________________
Have surgery? (dates, type)	Y ☐ N ☐	____________________
Take drugs? (antibiotics, vaccines)	Y ☐ N ☐	____________________
Falls that cause banging on head?	Y ☐ N ☐	____________________
Falling from a chair?	Y ☐ N ☐	____________________
Yanked/pulled by arm?	Y ☐ N ☐	____________________
Experience other traumas/stresses?	Y ☐ N ☐	____________________

YOUR CURRENT HEALTH CONDITIONS

AS AN ADULT, DID YOU EVER:

Receive Chiropractic Care (Prior To Today)?	Y ☐ N ☐	____________________
Eat healthy foods regularly?	Y ☐ N ☐	____________________
Drink 8-10 glasses of water per day?	Y ☐ N ☐	____________________
Exercise regularly?	Y ☐ N ☐	____________________
Smoke? (amount each day)	Y ☐ N ☐	____________________
Drink alcohol? (number of drinks each week)	Y ☐ N ☐	____________________
Have any auto accidents? (dates)	Y ☐ N ☐	____________________
Utilize drugs? (prescription / non-prescription)	Y ☐ N ☐	____________________
Have any surgeries? (dates)	Y ☐ N ☐	____________________
Sleeping problems?	Y ☐ N ☐	____________________
Have/had occupational/work stresses?	Y ☐ N ☐	____________________
Sports or hobby injuries? (dates, type)	Y ☐ N ☐	____________________

Addressing The Issues That Brought You Into Our Office

Reasons For Today's Visit ______________________

How long have you suffered with this problem? ______________________

What have you tried to resolve this problem and DID NOT work? ______________________

Have you become discouraged about the problem? ______________________

When this problem is at its worst, how does it make you feel? ______________________

Does it interfere with... work family hobbies life exercise ______________________

What activities make this problem worse? ______________________

What activities make this problem better? ______________________

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping yourself solve this problem: ______________________

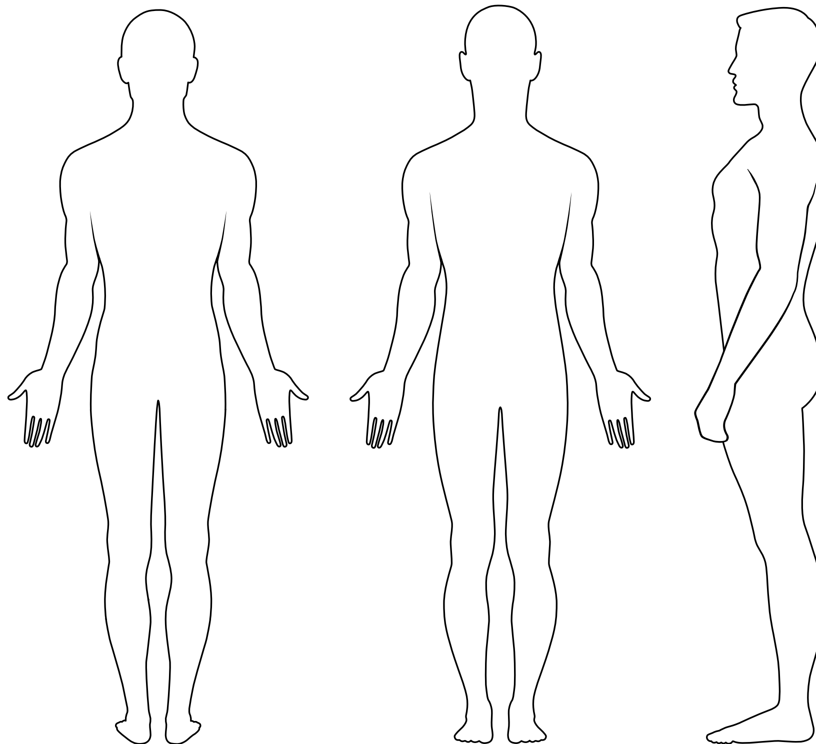
Other Complaints (even if they do not seem to be related to your visit today)

Circle all that apply

Low Back Pain	Tension Across Shoulders	Weight Trouble	Digestive Problems
Allergies/Asthma	Numbing/Tingling in Arms/Hands	Nervousness	Pain between Shoulders
Neck Pain	Numbing/Tingling in Legs/Feet	Irritability	Tension/Migraine Headaches
Frequent Colds	Dizziness	Menstrual Problems	Difficulty Sleeping
Tired, Fatigued	Ear Infections/Ringing	Stomach/ Bowel	Difficulty Bending/Lifting
High Blood Pressure	Muscle Spasms	Depression	Inability to do Sports/Hobbies

What Is Your Body Telling You?

Indicate Area of Pain:



Member Signature: ______________________ Date: ______________________