DR. GENE A. BERGMANN

CONFIDENTIAL PATIENT REGISTRATION INFORMATION

Account No.:_____
Case Type:_____
X-RAY ID:_____

TODAY'S DATE
/ /

1 PATIENT INFORMATION

LAST NAME	FIRST	MI	WHAT YOU PREFER TO BE CALLED:

HOME STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	E-MAIL ADDRESS

SEX	AGE	BIRTH DATE	SOC. SEC. NO.	Marital Status
		/ /		☐SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED

DRIVER'S LICENSE #	PATIENT STATUS	WHO REFERRED YOU TO THIS OFFICE?	NO. OF CHILDREN
	☐NEW ☐RETURNING		

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE?	IF YES, WHOM?
☐YES ☐NO	

OCCUPATION	EMPLOYER	WORK PHONE

EMPLOYER STREET ADDRESS	CITY	STATE	ZIP CODE

SPOUSE"S NAME	SPOUSE"S BIRTH DATE	SPOUSE'S SOC. SEC. NO.
	/ /	

SPOUSE"S OCCUPATION	SPOUSE"S COMPANY NAME	SPOUSE"S COMPANY ADDRESS	PHONE

2 IN CASE OF EMERGENCY CONTACT

CONTACT NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

3 ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT?	TYPE OF ACCIDENT
☐NO ☐YES IF YES, DATE OF ACCIDENT ___/___/___	☐AUTO ☐WORK ☐HOME ☐OTHER

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT?	ATTORNEY NAME (IF APPLICABLE)
☐AUTO INSURANCE ☐EMPLOYER ☐WORKER COMP. ☐OTHER_____	

4 INSURANCE INFORMATION

INSURANCE COMPANY NAME:	ADDRESS:	PHONE #:

CARD HOLDER'S NAME:	CARD HOLDER'S SS#:	CARD HOLDER'S BIRTHDATE:
		/ /

PATIENT's RELATIONSHIP TO INSURED:	CARD HOLDER'S EMPLOYER:
☐SELF ☐SPOUSE ☐CHILD ☐OTHER _____	

PAYMENT IS EXPECTED AT TIME OF VISIT!

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our Policy requires payment in full for all services rendered a the time of visit, unless other arrangements have been made wiith the business manager. If account is not paid within 90 days of the date of servcie and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

*Signauture:*_____ *Date:*_____

☐Adult Patient ☐Parent or Guardian ☐Spouse

HEALTH QUESTIONNAIRE

SYMPTOMS (Please Mark Appropriate Box)

HEAD:

[] Headache
  [] Entire Head
  [] Back of Head
  [] Forehead
  [] Temples
  [] Migraine
[] Loss of Memory
[] Light-Headedness
[] Fainting
[] Dizziness
[] Lights Bother Eyes
[] Loss of Smell
[] Loss of Taste
[] Loss of Balance
[] Loss of Hearing
[] Pain in Ears
[] Ringing in Ears
[] Buzzing in Ears

NECK:

[] Pain in Neck
[] Neck Pain with Movement
[] Pinched Nerve in Neck
[] Neck Feels out of Place
[] Stiff Neck
[] Muscles Spasms in Neck
[] Grinding Sounds in Neck
[] Popping Sounds in Neck
[] Arthritis in Neck

SHOULDERS:

[] Pain in Shoulder Joint (R-L)
[] Pain Across Shoulders
[] Bursitis (R-L)
[] Arthritis (R-L)
[] Can't Raise Arm
  [] Above Shoulder Level
  [] Over Head
[] Tension in Shoulders
[] Pinched Nerve in Shoulders
[] Muscle Spasms in Shoulders

ARM & HANDS:

[] Pain in Upper Arm (R-L)
[] Pain in Forearm (R-L)
[] Pain in Hands (R-L)
[] Pain in Fingers (R-L)
[] Pins & Needles Sensation in Arms (R-L)
[] Pins & Needles Sensation in Fingers (R-L)
[] Hand goes to Sleep (R-L)
[] Hands get Cold
[] Swollen Joints in Fingers
[] Arthritis in Fingers
[] Loss of Grip Strength

MID-BACK:

[] Mid Back Pain
[] Pain Between Shoulder Blades
[] Sharp Stabbing Pain in Mid-Back
[] Muscle Spasms

CHEST AND ABDOMEN:

[] Crushing Weight Feeling on Chest
[] Chest Pain
[] Shortness of Breath
[] Pain with Deep Breath
[] Pain Around Ribs
[] Abdominal Pain
[] Nausea
[] Constipation
[] Diarrhea

WOMEN ONLY:

[] Pregnant
[] Menstrual Pain
[] Cramping
[] Irregularity
[] Vaginal Discharge
[] Vaginal Pain
[] Breast Pain
[] Lumps in Breast

Date of Last Menstrual Period:

_____

LOW BACK:

[] Low Back Pain
[] Low Back Pain Worse When
  [] Working
  [] Lifting
  [] Stooping
  [] Standing
  [] Sitting
  [] Bending
  [] Coughing
  [] Sneezing
[] Pinched Nerve in Low Back
[] Slipped Disk
[] Low Back Feels out of Place
[] Muscle Spasms
[] Arthritis

HIPS, LEGS, & FEET

[] Pain in Buttocks (R-L)
[] Pain in Hip (R-L)
[] Groin Pain (R-L)
[] Pain Down Leg (R-L)
[] Pain Down Both Legs
[] Leg Cramps
[] Pins & Needles in Legs (R-L)
[] Numbness of Leg (R-L)
[] Knee Pain (R-L)
[] Numbness of Feet (R-L)
[] Numbness of Toes (R-L)
[] Feet Feel Cold
[] Swollen Feet or Ankles
[] Painful Joints in Toes

GENERAL:

[] Rapid Weight Gain or Loss
[] Fatigue or Run Down
[] Nervousness/Nervous Tension
[] Excessive Thirst
[] Excessive Hunger
[] Frequent Urination
[] Bloody Urine
[] Bloody Stool

What is your major complaint?_____

Date of onset of symptoms:_____Have you had this or similar conditions in the past? Yes [] No []. If yes, when?_____

What activities make your condition worse?_____

_____

What makes your condition feel better?_____

_____

Other Doctors seen for this conditon:_____

_____

Name and address of your personal Medical Physician:_____

_____

Are you seeing this or any other Doctor for any other condition? Yes [] No []. If yes, explain:_____

List types and dates of past hospitalizations and operations:_____

_____

List medications you are taking now:_____

_____

Any additional information or comments:_____

_____

Patient's Signature:_____Date:_____