OSTERBERG
Chiropractic Centre

Welcome

*Thank you for choosing **Osterberg Chiropractic Centre** for your chiropractic needs. Please complete the following information. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.*

Patient Information

Name: ______________________ DOB: __________ SSN: ______________

Address: ______________________ City: ______________ State: _____ Zip: __________

Home Ph: ______________ Cell Ph: ______________ Email: ______________

Emergency Contact: ______________________ Ph: ______________

Spouse Name: ______________ Whom may we thank for referring you? ______________

Occupation: ______________ Employer: ______________ Work Ph: ______________

Family Physician: ______________________ Clinic Name: ______________________

Symptoms

Reason for visit: ____

Is this injury due to a work or vehicle accident? Yes / No Is this the first episode of neck/back pain? Yes / No

How long have you experienced neck/back pain? ________ When did you first notice the symptoms? ________

What activities are difficult to perform?

□ Sitting □ Standing □ Walking □ Bending □ Lying Down □ Other ______________

Describe your type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Other ______________________

Rate the severity of your pain: [**1 = mild - 10 = worst possible**] (circle one) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? □ Constant □ Comes and goes

Other doctors that you have seen for this condition: ______________________

Diagnosis: ______________________ Treatment received: ______________________

X-rays taken? Yes / No Other tests performed? Yes / No

If yes, list test, where taken and results: ______________________

Health History (Check only those conditions which apply to you)

□ Allergies	□ Cardiac Arrhythmia	□ Epilepsy	□ High Blood Pressure	□ Neck Pain
□ Ankle Pain	□ Constipation	□ Female Disorders	□ Hip Pain	□ Osteoporosis
□ Arthritis	□ Chronic Bronchitis	□ Fractures	□ Indigestion	□ Shoulder Pain
□ Asthma	□ Depression	□ Headaches	□ Irritable Bowel	□ Stroke
□ Back Pain	□ Diabetes	□ Heart Disease	□ Kidney Disease	□ Ulcer
□ Blood Clots	□ Elbow Pain	□ Hernia	□ Liver Disease	□ Other __________
□ Cancer	□ Emphysema	□ Herniated Disc	□ Migraine	__________

(Women) Are you pregnant? Yes / No Taking birth control pills? Yes / No

Current Medications: ____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the doctors and staff of Osterberg Chiropractic Centre P.C. to administer treatment, physical examination, X-ray, chiropractic care and/or any other clinical service that they deem necessary in my case.

______________________________ ______________

Signature of Patient (or Parent/Legal Guardian if a minor) *Date*

______________________________ ______________

Print Name of Patient (or Parent/Legal Guardian if a minor) *Relationship to Patient*