Bergkamp Chiropractic LLC CONFIDENTIAL Health Information Pt ID#_____

Name:_____ Age:_____ Date:_____

Have you been in an accident or injured since your last visit here? NO YES _____

If YES, when?_____ Do you have an attorney on the case? NO YES

Have you had COVID? NO YES When?_____ Hospitalized? NO YES

SMOKING STATUS: No Yes Former ALCOHOL: Yes No Use: Cane Walker Chair

CANCER: NONE Breast Prostate Lung Colon Bladder Skin Thyroid Other

BROKEN BONES: NONE R / L:_____ R / L:_____
_____ R / L:_____ R / L:_____

NEURO: Headache Pins/Needles Muscle Loss of Unexplained Decreased
NONE Seizures Numbness Weakness Memory Pain Alertness

CONDITIONS: Addiction Anemia Anxiety Asthma Apnea Blood Disorder COPD
Depression Diabetes Disc (C T L) Dizzy Ear ringing Fibromyalgia Gerd Heart Attack
Hepatitis HIV AS IBS MRSA MS TB Liver/Kidney/Menstrual/Skin/Stomach Problems
Osteopenia/porosis RA Scoliosis Stenosis Stroke Thyroid Other:_____
If Pregnant, Due Date:_____ NO CONDITIONS Fall Risk: YES or NO

SURGERIES: Appendix Biopsy Cataract C-section Fusion Gall Bladder Heart
Hysterectomy Stent Jt Replaced:_____
Other:_____ NO SURGERIES

MEDICATIONS:_____
NONE BP Cholesterol Gerd Heart Anxiety/Dep BCP Thyroid Inhaler

Medication Allergies: NONE or _____

Family Member Health Conditions: NO CONDITIONS ADOPTED UNKNOWN
Mother:_____
Father:_____
Siblings:_____
Children:_____

I have disclosed all health history and will update Dr Jill asap. Patient Initial:_____

Patient Email Address:_____

Bergkamp Chiropractic and Massage Dr Jill Bergkamp-Engle DC NPI# 1669478509
11330 E Central Ave Ste 500 Wichita KS 67206 (P): 316.682.6161 / (F): 316.682.7650

Bergkamp Chiropractic LLC CONFIDENTIAL Health Information Pt ID#_____

Temp:_____ Ht:_____ Wt:_____ BP:_____/_____ P:_____
(Fill in best estimate please)

For each item below, please circle the words which best describe your condition right now:

Pain Level	None	Mild	Moderate	Severe	Worst Ever
Sleeping	Perfect	Mild Disrupt	Moderate	Greatly	Unable/No
Care of self	No Trouble	Mild Pain	Slow Care	Need Help	Disabled
Travel if you had to now	No Trouble	Mild Trouble Long Trips	Moderate Long Trips	Moderate Short Trips	Severe Short Trips
Daily Activity	Unlimited	Must Do list	50 % Usual	25% Usual	Unable to do
Recreation	Everything	Most hobbies	Some hobby	Few things	None
Frequency	No Pain	25% of day	50% of day	75% of day	100% of day
Lifting	No Pain	Heavy Wt	Moderate Wt	Light Wt	No Lifting
Walking	Any Distance	1 Mile Limit	½ Mile Limit	¼ Mile Limit	All walking
Standing	No Pain Limit	Several Hrs	After 1 Hour	½ Hour Limit	Any Standing
Sitting	No Pain	Several Hrs	After 1 Hour	½ Hour Limit	All Sitting

Problem #1:_____

With 10 being the worst pain ever, circle the number that best describes the problem now?
0 1 2 3 4 5 6 7 8 9 10

What were you doing?_____ When?_____

Problem quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the Problem Worse at certain times? Morning Afternoon Evening Night Unaffected

What makes it Worse? Bend Tilt Turn Twist Sit Stand Rise Up Lift Drive Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes it Better? Rest Ice Heat Stretch Exercise Massage Meds Adjust

I understand there is no guarantee of results and there are possible risks but I knowingly and willingly consent to receive a chiropractic treatment. Plan___/wk for ___/wks then re-eval/ref consider course changes with functional goals and ADL deficit outcomes. Dr Jill approval_____.

Patient Signature:_____ Date:_____

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Problem #2:_____

With 10 being the worst pain, circle the number that best describes the problem now?
0 1 2 3 4 5 6 7 8 9 10

What were you doing?_____ When?_____

Problem quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the Problem Worse at certain times? Morning Afternoon Evening Night Unaffected

What makes it Worse? Bend Tilt Turn Twist Sit Stand Rise Up Lift Drive Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes it Better? Rest Ice Heat Stretch Exercise Massage Meds Adjust

Problem #3:_____

With 10 being the worst pain, circle the number that best describes the problem now?
0 1 2 3 4 5 6 7 8 9 10

What were you doing?_____ When?_____

Problem quality? Sharp Dull Achy Burn Throb Stab Deep Nag Sting Shoot_____

Is the Problem Worse at certain times? Morning Afternoon Evening Night Unaffected

What makes it Worse? Bend Tilt Turn Twist Sit Stand Rise Up Lift Drive Walk Run Family Care Grocery Shop Household Chores Computer Yardwork Other_____

What makes it Better? Rest Ice Heat Stretch Exercise Massage Meds Adjust

Prior interventions - What have you done about the problems since your last visit here?
Medical Doctor Physical Therapy Home Remedies Acupuncture Chiropractic

Doctor Name:_____ Phone:_____

Imaging by:_____ When:_____

Recommendations:_____

What would be the most significant thing you could do to improve your health?_____

What else should Dr Jill know about you?_____