Bergkamp-Engle Chiropractic CONFIDENTIAL Health Information Pt ID#_____

Name:_____ Age:_____ Date:_____

SMOKING STATUS: No Yes Former ALCOHOL: Yes No 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 Numb Weakness Memory Pain Alertness

CONDITIONS: Anxiety Asthma Apnea COPD Depression Diabetes Disc Dizzy
Ear ringing Fibromyalgia Heart Attack Obesity Osteopenia/porosis Poor Posture RA
Scoliosis Stenosis Stroke Thyroid AS MS If Pregnant, Due Date:_____
Other:_____ NONE Fall Risk: YES or NO

SURGERIES: Appendix Biopsy Cataract C-section Fusion Gall Bladder Heart
Hysterectomy Jt Replaced:_____ Stent Other:_____ NONE

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:_____

Over the last 2 wks, how often have you been bothered by the following problems? Mark below:

| OPT OUT_____ | Not at all | Sometimes | Mostly | Everyday |
|---|---|---|---|---|
| Little interest in doing things | | | | |
| Feeling down or hopeless | | | | |
| Trouble falling or staying asleep | | | | |
| Feeling tired or having little energy | | | | |
| Poor appetite or overeating | | | | |
| Feeling bad about yourself | | | | |
| Trouble concentrating on things | | | | |
| Moving or speaking slowly or being restless | | | | |
| Thoughts that you would hurt yourself or others | | | | |

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

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-Engle Chiropractic CONFIDENTIAL Health Information Pt ID#_____

Temp:_____ Ht:_____ Wt:_____ BP:_____/_____ P:_____

For each item, 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 | No Trouble | Mild Trouble Long Trips | Moderate Long Trips | Moderate Short Trips | Severe Short Trips |
| Daily Activity | Unlimited | No Extra | 50 % Usual | 25% Usual | Unable to |
| Recreation | Everything | Most | Some | Few | 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 | Any Weight |
| Walking | Any Distance | 1 Mile | ½ Mile | ¼ Mile | All walking |
| Standing | No Pain | Several Hrs | After 1 Hour | ½ Hour | Any Standing |
| Sitting | No Pain | Several Hrs | After 1 Hour | ½ Hour | All Sitting |

**Problem #1**:_____

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

When did the Problem begin?_____ How?_____

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 chiropractic treatment. Dr Jill has COVID precautions in place to minimize the risk advised by CDC, NCMIC, KDHE, KCA, and SG Co Health Dept.

Patient Signature:_____ Date:_____

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**Problem #2**:_____

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

When did the Problem begin?_____ How?_____

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 imaginable, circle the number that best describes the problem?
0 1 2 3 4 5 6 7 8 9 10

When did the Problem begin?_____ How?_____

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 to relieve the above listed problems?**
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?_____