Berglund Chiropractic & Wellness, LLC
Confidential Patient History

Personal History

Today's Date _____

Patient's Name _____ Soc. Sec. # _____
Address _____Apt. #____ City _____ State ____ Zip _____
Age _____ Birth Date _____ Marital Status: M S D W # Children _____
Cell Phone _____ Work Phone _____ Home Phone _____
Email Address _____
Occupation _____ Employer _____
Spouse's Name _____ Spouse's Employer _____
How Did You Hear About Us? _____

Current Health Condition

Major Complaint(s): _____
_____
_____
Other Doctors Seen For This Condition? ☐ Yes ☐ No Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has It Occurred Before? ☐ Yes ☐ No
Is This Condition Getting: ☐ Better ☐ Worse ☐ Same
Cause of Condition: ☐ Unknown ☐ Work Injury ☐ Auto Accident ☐ Fall ☐ Other_____
Date of Accident: _____ Reported To Employer &/or Insurance Co.? ☐ Yes ☐ No
Women: Are You Pregnant At This Time? ☐ Yes ☐ No
What Medications Are You Taking? _____
Please List Any Other Health Conditions? _____
_____

Health History

Previous Chiropractic Care? ☐ None ☐ Yes - Doctor's Name: _____
Check Any That You Currently Experience or Have Had During The Past 6 Months:

☐ Headaches	☐ Low Back Pain	☐ Asthma	☐ High Blood Pressure
☐ Neck Pain	☐ Pelvis/Hip/Leg Pain	☐ Allergies	☐ Nausea/Vomiting
☐ Shoulder Pain	☐ Numbness/Tingling	☐ Diabetes	☐ Dizziness
☐ Arm Pain	☐ Fatigue	☐ Cancer	☐ Nervousness
☐ Mid Back Pain	☐ Digestive Disorders	☐ Heart Problems	☐ Mental Disorders

Please List Any Major Surgical Operations and Year Occurred: _____

Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort **(relief care)**. Others are interested in having the *cause* of their problem corrected *as well as their symptoms* relieved **(corrective care)**. Dr. Berglund will consider your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:
□ Relief Care □ Corrective Care □ Check here if you want the Doctor to select the type of care most appropriate for your condition.

Insurance Information

Do You Have Health Insurance? □ Yes □ No

Name(s) of Insurance Company(s) _____Policy # _____

Consent to receive Email and/or Text Messages

I consent to receiving appointment reminders, notification of office closings, or other general healthcare related communications/information via email and/or texts to my cell phone from Berglund Chiropractic & Wellness, LLC. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patient's Signature: **X** _____ Cell Phone Carrier Name _____

Payment Acknowledgment (please Sign)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me or my dependent will be immediately due and payable. Outstanding balances over 30 days may be assessed interest charges at the rate of 1.5% monthly.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature: **X** _____ Date _____

Guardian or Spouse's
Signature Authorizing Care: _____ Date _____

I hearby authorize and direct my insurance benefits to be paid directly to the Doctor. I am financially responsible for non-covered services.

Patient's Signature: **X** _____ Date_____

_____