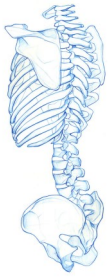


Wishek Chiropractic Clinic

Dr. Eric Froehling ~ Dr. Clarissa Volk
Wishek ~ Ashley ~ Herreid ~ Strasburg

Date: _____

About You

Patient Name: _____
Full Legal First Last Middle Initial

What do you prefer to be called: _____

Mailing Address: _____

Residential Address: (if different)_____

_____
City State Zip

Home Phone_____

Work_____

Cell Phone_____

Birth date: ____/_____/_____

Social Security Number: _____

Male ☐ *Female* ☐

Marital Status: (circle one) *Single* *Married* *Other*

Spouses Name: _____

Do you have Children? *Yes* *No* How many? _____

Race: (circle one)
White *Black/African* *Hispanic* *Indian/Alaskan Native* *Other*

Employment Status: (circle one)

Employed *Student* *Retired* *Self Employed*

Occupation

_____

Employers Name

_____

_____
Address City State Zip

Emergency Contact_____

Relation_____

Phone _____

Medical Doctor_____

Please provide your chief complaint or concerns.

_____

_____

_____

When did condition begin? _____

***Please turn the page and fill out the back.**

Wishek Chiropractic Clinic
PO Box 125
Phone: 452-2593
Fax: 452-2763

"Committed to Chiropractic Excellence"

Please provide your chief complaint or concerns.

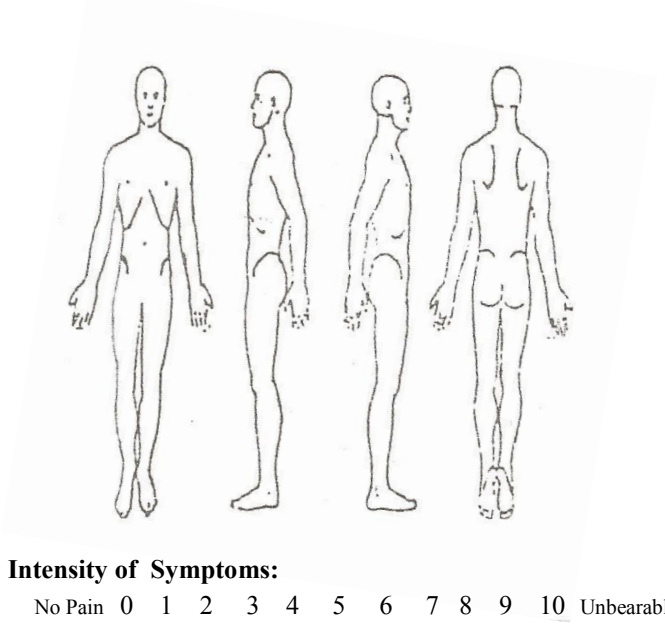
_____

_____

_____

When did condition begin? _____

Please mark the areas of symptoms on the diagram.



Intensity of Symptoms:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Do you have any family history of serious illness or disease? (such as diabetes, heart disease, cancer) _____

_____

Any recent weight change (more than 10 lbs in a month)?

Yes ☐ *No* ☐

Have you had any problems with the following systems?
If yes, give a brief explanation.

Skin	Yes ☐	No ☐	_____
Eyes, Nose, Throat	Yes ☐	No ☐	_____
Lungs or Breathing	Yes ☐	No ☐	_____
Heart	Yes ☐	No ☐	_____
Digestion	Yes ☐	No ☐	_____
Urination	Yes ☐	No ☐	_____
Neurologic	Yes ☐	No ☐	_____
Blood disorder	Yes ☐	No ☐	_____
Endocrine	Yes ☐	No ☐	_____
Psychiatric	Yes ☐	No ☐	_____

List current medications, including dosage. If you have a list we are able to copy it for you.

If no medication check here ☐

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Are you taking any over-the-counter medications? *Yes* ☐ *No* ☐

If yes, please specify including dosage:_____

_____

Do you have any allergies to Rx medication? *Yes* ☐ *No* ☐

If yes, please specify:_____

_____

Are you taking any nutritional supplements? *Yes* ☐ *No* ☐

If yes, please specify including dosage:_____

_____

What other health problems/surgeries do (did) you have? Briefly list them.

_____

_____

_____

For Women: Are you taking Birth Control? *Yes* *No*

Are you pregnant? *Yes* *No* How long? _____