Bartz Chiropractic Office **A 100 Year Lifestyle Licensed Affiliate**
www.bartzchiropracticlifestyle.com 203 W Walworth St. Elkhorn, WI 53121 262-723-6203

Date_____

Name _____ Referred By _____

Address _____ Occupation _____

City _____ State ____ Zip _____ Employer _____

Phone: (H) _____ (W) _____(C)_____/Cell Carrier_____ Marital Status S M D W

E-mail _____ Spouse's Name _____
Date of Birth _____ (Age _____) Spouse's Occupation _____

Number of Children and Ages ***Previous Chiropractic Care?***

I am currently pregnant Yes_____No_____Due date_____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

Circle all that Apply	**Self**	**Spouse**	**Child**	**Child**	**Child**	***Comments***
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke/Vape?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____

Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

List any **Allergies**: (None known___)

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen
□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other:_____

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List any **Surgeries**: (none___)

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other:

_____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression
□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain
□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure
□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain
□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's
□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain
□ Stroke/Heart Attack □ Other:

_____

List Name of **Medications** you are taking **and what they are for**: (none_____)

□ Anxiety □ Muscle Relaxors □ Pain Killers □ Insulin □ Birth control □ Cardiovascular □ Allergy □ Seizure
□ Other: _____(we would be happy to make a copy of your list if you have one)

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

****

List your **Family History**: Please specify (Maternal or Paternal)

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition
□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio
□ Prostate Problems □ Stroke/Heart Attack □ Please list all family members who had/has any of the problems above:
(**Example: Paternal Grandmother – High blood pressure)

_____

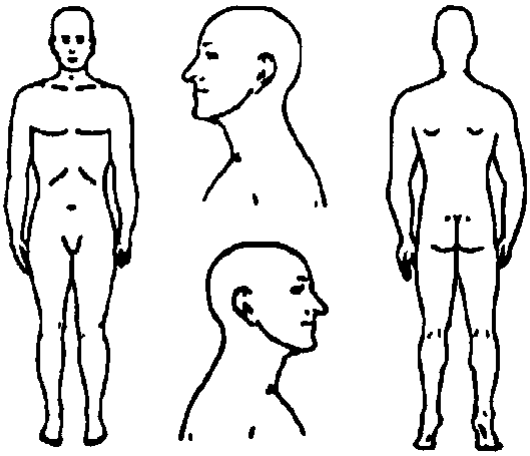
_____

_____

Your oldest grandparent on record lived to the age of _____.

❒ Still living ❒ Deceased

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



(Please list each AREA separately, thank you)

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? Please be specific

_____

Have you experienced this condition in the past? □Yes □No

Which side: □Left side □Right side □Bilateral □Center

Pain Level: Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □None

Intensity: Please rate the intensity of your pain: □Minimum □Mild □Moderate □Severe □Unbearable □None

Nature: Describe the nature of your symptoms: □ Burning □ Dull ache □ Numb □ Radiating Pain □ Sharp □ Shooting □ Stabbing □ Tightness □ Tingling □ Throbbing □ Other: _____

What makes your pain better (ice, heat, massage, etc)? □Acupuncture □Chiropractic therapy □Heat □Ice □Massage Therapy □Nothing works □Pain Medication □Physical Therapy □Sleep/Rest □Stretching □Therapy □Other

Frequency: How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day)

□ Intermittently (0-25% of the day)

What activities aggravate your condition? (Twisting, bending, sitting, standing, rising, stairs, turning head, lifting, reaching, other) _____

What is your SECOND area of complaint? _____Date problem began?_____

How did this problem begin (falling, lifting, etc.)? Please be specific

_____

Have you experienced this condition in the past? □Yes □No

Which side: □Left side □Right side □Bilateral □Center

Pain level: Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □none

Intensity: Please rate the intensity of your pain: □Minimum □Mild □Moderate □Severe □Unbearable □None

Nature: Describe the nature of your symptoms: □ Burning □ Dull ache □ Numb □ Radiating Pain □ Sharp □ Shooting □ Stabbing □ Tightness □ Tingling □ Throbbing □ Other: _____

What makes your pain better (ice, heat, massage, etc)? □Acupuncture □Chiropractic therapy □Heat □Ice □Massage Therapy □Nothing works □Pain Medication □Physical Therapy □Sleep/Rest □Stretching □Therapy □Other

Frequency: How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day)

□ Intermittently (0-25% of the day)

What activities aggravate your condition? (Twisting, bending, sitting, standing, rising, stairs, turning head, lifting, reaching, other) _____

What is your Third area of complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? Please be specific _____

Have you experienced this condition in the past? □Yes □No

Which side: □Left side □Right side □Bilateral □Center

Pain Level: Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □None

Intensity: Please rate the intensity of your pain: □Minimum □Mild □Moderate □Severe □Unbearable □None

Nature: Describe the nature of your symptoms: □ Burning □ Dull ache □ Numb □ Radiating Pain □ Sharp □ Shooting □ Stabbing □ Tightness □ Tingling □ Throbbing □ Other: _____

What makes your pain better (ice, heat, massage, etc)? □Acupuncture □Chiropractic therapy □Heat □Ice □Massage Therapy □Nothing works □Pain Medication □Physical Therapy □Sleep/Rest □Stretching □Therapy □Other

Frequency: How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day)

□ Intermittently (0-25% of the day)

What activities aggravate your condition? (Twisting, bending, sitting, standing, rising, stairs, turning head, lifting, reaching , other)_____

Have you seen a Chiropractor before? Yes No

When?_____Where?_____Xrays taken?_____

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

- ❒ **Feel better quickly □Be able to play w/ kids/grandkids □Take long walks □Participate in sports/ leisure activities □Sleep well □Drive car/long car rides w/o pain □work w/o pain□ Rise from chair**
- ❒ **Have a healthier spine and nervous system**
- ❒ **Live a healthier lifestyle**

_____ _____

Signature Date