Dr. Michael W. Bohrnsen DC, DACBSP
15312 E. Sprague Ave. #23
Spokane Valley, WA 99037
(509)828-0538

Confidential Patient Information

Patient's Name____ Today's Date:_____/_____/_____
Last First(legal) Initial

Home Phone: ________________________ Cell Phone: ______________________Mailing
Address:____ City:_______________ State:______ Zip:____________
E-Mail: ____ ___ Male ___ Female___
DOB__/____/______ Age:____________ Social Security # :________ - ________ - ________

Occupation:_________________
Employer:_____________________ Business Phone:_________________
Emergency Contact:__________________________Relationship:______________________

Phone: ______________________Address:_________________________________ City:________________________

State:______________ Zip: _____________

Financial Information for Responsible Party if NOT the Patient (patient is a minor)

Last Name:____________________________________ First Name:_________________________ Initial:_______

Address:____ City:___________________State/Zipcode:______________

Home Phone:_____________________ Cell Phone:_____________________ Email:_________________________________

Date of Birth______________ Driver's License #________________________ SSN___________________________

Employer:__________________________________ Business Phone:___________________________

Concurrent Health Care

Are you receiving treatment for this problem? Yes/NO

Family Physician:___________________________ City______________________ State______ Zipcode____________

How were you referred to us?____

Insurance Information

Do you have Health Insurance? Yes/No Insurance Company Name____

**Note: Your insurance is an agreement between you and your insurance company & it is your responsibility to know your benefits. If you need a referrall or pre-authorization for care you need to take care of that before being seen. We will gladly bill your primary insurance for you.

Have you had Previous Chiropractic/Physical Therapy Care? If YES, for what problems? ________________________

____

Dr. Michael W. Bohrnsen DC, DACBSP
15312 E. Sprague Ave. #23
Spokane Valley, WA 99037
(509)828-0538

Average: 0 1 2 3 4 5 6 7 8 9 10
0 = No Pain 10= worst pain imaginable
Descriptions for Pain

Pain: Worst: 0 1 2 3 4 5 6 7 8 9 10

Best: 0 1 2 3 4 5 6 7 8 9 10

Numbness Pins/ Needles Aching Sharp Burning Radiating Stabbing

Is Today's Visit for a **Work Related Injury**? Yes/No **Auto Accident**? Yes/No
(if the answer is yes, please let doctor know because additional information will be needed)
Attorney for Account________________________________ Phone__________________ Fax____________________

Address____ City________________ State_____ Zip code_____________

Please Complete this brief Health Questionnaire. If you need assistance, please ask. Your answers will help us determine how Chiropractic and therapy can help you.
Chief Complaint:____ Date of Onset_____________
Secondary Complaint if any____ Date of Onset ______________

What Treatment have you already had for these conditions?____

Is this condition due to a: Work Injury _____ Auto ____ Other Accident ____Illness ____Unknown Cause ____Other

Have you had similar symptoms before?______________

Are Your symptoms generally _____ Improving _____ Getting Worse ____ Staying the Same

Are Your Symptoms: _____ Constant ______ Off and On

List Any Physical Limitations related to your symptoms: ____

My Symptoms interfere with: _____ Work _____ Recreation ___ Sleep ____ N/A

What Positions/Activities make your Symptoms Worse? ____

What Position/Activities make your Symptoms Better? ____

Describe the Pain and How it Happened: ____

____

Please Mark location(s) of PAIN/Injury

Family Health History: (I.E: cancer, emphysema, diabetes, high blood pressure, heart attack)

Serious illnesses in your household? ____

Mother Living? _______________ Serious Illness?____

Father Living? ________________ Serious Illness? ____

Brothers: Number ____________ Serious Illness?____

Sisters: Number _____________ Serious Illness? ____

Past Medical History

Circle All that Apply:

AIDS, HIV Alcoholism Arthritis Asthma Cancer Stroke Cholesterol Depression Diabetes

Epilepsy Heart Disease Thyroid Hepatitis Pacemaker Prostate Tuberculosis Tumors High Blood Pressure

Dr. Michael W. Bohrnsen DC, DACBSP
15312 E. Sprague Ave. #23
Spokane Valley, WA 99037
(509)828-0538

Other Illnesses ____

Auto Accidents ____

Work Injuries ____

Surgeries and Approximate Dates____

Current Medications ____

Allergies ____

SOCIAL HISTORY and LIFESTYLE ISSUES:

Marital Status:_______________ Spouses Name: _____________ Dependents _______________

Education: _______________________________________ Military: _______________________

Avg. Sleep Per Day: _____ Hours Do you fall asleep easily: YES/NO Do you awake Rested: YES/NO

Major Stress in the last 6 months ? ____

Substance Abuse: Caffeinated Drinks Per Day ____________ Tobacco-Packs or tins per week _________

Alcohol Drinks per day ________________ Illicit Drugs: _____________________

Do you Exercise Regularly? _________________ What Kind? ____________________________________

Hobbies/Interests ____

Dr. Michael W. Bohrnsen DC, DACBSP
15312 E. Sprague Ave. #23
Spokane Valley, WA 99037
(509)828-0538

INFORMED CONSENT

Medical doctors, chiropractic doctors, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment. I___________________________________, Do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising

I am aware that like exercise it is common to experience muscle soreness and occasionally bruisin gin the first few treatments.

Dizziness

Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury

I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Physical Therapy Burns

Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these

procedures by my doctor and such other persons of the doctor’s choosing.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and free

Sign below

Signature of Patient ____ Date__________________

Signature of Parent or Guardian (if a minor) ____Date____________

Signature of Witness ____ Date_____________