BERGMAN FAMILY CHIROPRACTIC

Renew, Restore, Regenerate

Date: _____ Account # _____

HEALTH & STRESS SURVEY

Name _____ **Age** ____ **Phone (home)** _____ **Cell** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Email Address _____ **Would like to Receive our Free E-News? Y / N**

Place of Employment _____ **Job Title** _____

Social Security # _____ **Date of Birth** _____

Are You Married? Y / N Do You Have Children? Y / N Are They Currently Under Care Here? Y / N

Emergency Contact (Relationship) _____ **Phone #** _____

How were You Referred? _____

1. Check off any of the following symptoms you have experienced in the past 6 months:

_ Low back pain	_ Elbow pain	_ Tension Across top of shoulders
_ Dizziness	_ Shoulder pain	_ Pain between shoulder blades
_ Neck pain	_ Hip pain	_ Numbness or tingling in arms
_ Tension Headaches	_ Knee pain	_ Numbness or tingling in legs
_ Tired/Fatigued	_Ankle/ Foot pain	_ Difficulty sleeping
_ Wrist/ Hand pain	_ Ringing in ears	_ Allergies
_ Digestive problems	_ Weight problems	_ Nervousness

Which of the above is worse? _____

How long have you had it? _____

What medications are you taking? _____

WOULD YOU LIKE TO GET RID OF THE PROBLEM? ____Yes ____No