

ELITE PHYSICAL THERAPY AND WELLNESS

ELITE CHIROPRACTIC AND WELLNESS

Craig Brechler, PT

Marcella Brechler, DC

Name _____	Date _____
Address _____	How did you hear about our office? _____
City _____ State _____ Zip _____	Home Phone# _____
Cell# (For Confirming Appointment) _____	Carrier: <input type="checkbox"/> Verizon <input type="checkbox"/> ATT Wireless <input type="checkbox"/> T-Mobile <input type="checkbox"/> Other _____
E-mail Address (For Confirming Appointment) _____	
SSN _____	Date-of-Birth _____ Age _____ Height _____ Weight _____
Male Female Single Married Divorced # of children _____	Name of Spouse (or Parent) _____
Employer _____	Occupation _____
Address _____	
City _____ State _____ Zip _____	Work Phone _____
What is the name of your family physician? _____ What city are they located in? _____	
Have you ever had Chiropractic care before? _____ If yes, doctor name: _____ Date-of-Last Visit _____	
If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity	
1. _____	For how long? _____
2. _____	For how long? _____
3. _____	For how long? _____
4. _____	For how long? _____
Has this problem been getting <input type="checkbox"/> worse or <input type="checkbox"/> staying the same?	
Currently or in the past have you ever experienced any of these complaints while working? _____	
If yes, please describe what activities at work may be causing you these complaints: _____	
Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____	
If yes, please explain: _____	
Have you at any time in the past ever suffered a work injury? _____ Yes _____ No If yes, what is the date of injury? _____	
Do you have an attorney representing you for this work injury? _____ Yes _____ No If yes, who is your attorney? _____	
Have you been involved in an auto accident in the last 12 months? _____ Yes _____ No If yes, date of the auto accident? _____	
Do you have an attorney representing you for this auto accident? _____ Yes _____ No If yes, who is your attorney? _____	
How many other passengers were in the car with you? _____	
List other doctors consulted for these conditions: 1. _____ 2. _____	
Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____	
Please list any current or past injuries and illnesses not listed above: _____	
Please check all medications (over the counter and/or prescribed) you are currently taking: <input type="checkbox"/> Aspirin/Tylenol <input type="checkbox"/> Pain killers <input type="checkbox"/> Muscle Relaxer	
<input type="checkbox"/> Insulin <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Sleeping Pills <input type="checkbox"/> Anti-depressants <input type="checkbox"/> Others _____	
Health Insurance Co. Name _____	Policy Holder _____
Name of Spouse's health insurance (If applicable) _____	Policy Holder _____
Spouse's Health Insurance Claims address _____	Policy Number _____

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www.EliteChiropracticAndWellness.com

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