

BALLAS CHIROPRACTIC CENTRE

Dr. David K. Wipperman

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Name	Last	First	Middle Initial
Address		City	State Zip
Referred by _____		Home Phone (_____) _____	
Patient's Social Security No. _____		Work Phone (_____) _____	
Occupation _____		No. of Children _____	
E-mail Address _____			
Date of Birth ____ - ____ - ____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	
Employer's Name _____			
Insurance Plan Name or Program Name _____			
Patient Relationship to Insured (check one) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Insured's Name _____			
Spouse's Name _____		Spouse's Soc. Sec. No. _____	
Spouse's Employer _____		Work Phone (_____) _____	
In case of emergency, another nearest relative not living with you:			
Name _____		Phone (_____) _____	
Family Physician's Name/Address _____			

YOUR BACKGROUND OF ACCUMULATIVE FACTORS CONTRIBUTING TO DECLINING HEALTH

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting before birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS (to age 15)	YES	NO	COMMENTS:
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
While learning to walk, did you fall head first?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet? (i.e., crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	_____
YOUR ADULT YEARS (age 15 to present)			
Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you play any adult sports / extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your stress level:
(1 = None / 10 = Extreme)
Occupational _____ Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

People who have already experienced Chiropractic Wellness Care and are here to continue, need only check here **"Wish to continue My Chiropractic Wellness Experience."** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

Describe your pain:

Sharp Dull Comes and goes Travels Constant

Problem started _____ It's getting better It's getting worse

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list):

- Chiropractor _____
 Medical Doctor _____
 Specialist _____

Please check (✓) all symptoms you have, even if they do not seem related to your current problem:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn/Ulcers |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain/Irregularity | <input type="checkbox"/> Cough/Sore Throat | <input type="checkbox"/> Upper Respiratory Infections |

List any medication you are taking: _____

Health conditions of:

Children _____
Mother _____
Father _____
Siblings _____

X-RAY CONFIRMATION: This is to confirm that I have been advised by the Doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic examination.

Signed _____ Date _____

CONSENT TO TREAT MINOR/CHILD: I hereby authorize the Doctor to administer chiropractic care as deemed necessary to

my _____ (indicate relationship to child)

Name _____

Signed _____ Date _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature _____ Date _____