

# Beutel Chiropractic & Wellness Center, Dr. Ember Beutel, D.C.

## Personal and Family Health History

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
 Please Print First Middle Initial Last  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone (H) \_\_\_\_\_  
 (W) \_\_\_\_\_ (C) \_\_\_\_\_  
 E-Mail \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
 Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Marital Status S M D W

Employer \_\_\_\_\_  
 Name of Primary Insurance \_\_\_\_\_  
 Spouse/Parent Name \_\_\_\_\_  
 Spouse/Parent Employer \_\_\_\_\_  
 Spouse/Parent SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of Secondary Insurance \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_  
 Emergency Contact # \_\_\_\_\_  
 Referred By: \_\_\_\_\_

Please List Children	Age	Chiropractic Care?	Reason:
1.			
2.			
3.			
4.			

This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us in determining if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you, Dr. Beutel.

1. Was Your Birth Traumatic?	Patient	Spouse	Child 1	Child 2	Child 3	Child 4
Long Delivery?						
Difficult Delivery?						
Forceps?						
Caesarian?						
Breach/cephalic?						
Home Birth?						
Mother given drugs during delivery?						

2. Growth & Development, did you ever...	Patient	Spouse	Child 1	Child 2	Child 3	Child 4
Learn to care for your spine?						
Fall out of bed?						
Bang your head?						
Breastfed?						
Childhood sickness?						
Have any accidents?						
Have surgery?						
Take drugs?						
Fall while learning to walk?						
Bullied by your siblings?						
Chair pulled out when sitting?						
Fall down the stairs?						
Pulled by your arm?						
Experience other traumas?						

**MEDICATIONS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Current Health Habits	Patient	Spouse	Child 1	Child 2	Child 3	Child 4
Smoke?						
Drink? (alcoholic beverages)						
Diet? (eat healthy foods)						
Been in accidents?						
Had organs replaced/removed?						
Drugs? Rx or non Rx						
Have teeth problems?						
Have eye problems?						
Have hearing problems?						
Exercise regularly?						
Have sleeping problems?						
Have occupational stress?						
Have physical stress?						
Have mental stress?						
Have hobbies/sports injuries?						

Sleeping posture? (circle one) side stomach back  
 Are you **pregnant**? Y N  
 Have you seen a Chiropractor before? Y N  
 Doctor seen \_\_\_\_\_ Last visit date \_\_\_\_\_  
 Previous issue \_\_\_\_\_  
 Do you have a **pacemaker**? Y N  
 Have you ever had any **surgeries**? Y N What and When?

\_\_\_\_\_  
 \_\_\_\_\_

**VITAMINS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Health Condition**

Present Complaint – Reason for Your Visit Today

Major \_\_\_\_\_

Pain or Problem started on \_\_\_\_\_

Pains are:     Sharp     Dull     Constant     Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Other doctors seen for this condition? \_\_\_\_\_

Any home remedies? \_\_\_\_\_

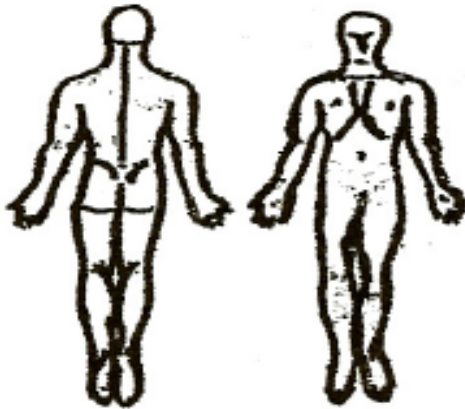
**Accident Information**

Is condition due to an accident?    Y    N    Date \_\_\_\_\_

Type of accident     Auto     Work     Home     Other

To who have you made a report of your accident?     Auto Insurance     Employer     Worker Comp     Other

**Mark an X on affected areas**



**Other symptoms:**

- Headaches
- Dizziness
- Light Bothers Eyes
- Loss of Memory
- Loss of Taste
- Loss of Smell
- Loss of Balance
- Buzzing in Ear
- Ringing ;in Ear
- Face Flushed
- Fever
- Fainting
- Cold Sweats
- Depression
- Nervousness
- Fatigue
- Tension
- Neck Pain
- Stiff Neck
- Chest Pains
- Shortness of Breath
- Back Pain
- Sleeping Problem
- Stomach Upset
- Constipation
- Diarrhea
- Irritability
- Cold Hands
- Cold Feet
- Numbness in Fingers
- Numbness in Toes
- Pins & Needles in Arms
- Pins & Needles in Legs
- Other \_\_\_\_\_

**Family Health History:**

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Today, Dr. Beutel will take a complete history and examine your condition to see if chiropractic can help you. On your second visit, you will receive a report of your exam findings and be presented with a care plan to best suit your condition.

Thank you for taking time to fill out the intake form. Sincerely, Dr. Ember Beutel, D.C.

\_\_\_\_\_  
(Patient/Guardian signature)