Intermountain Wellness Center
1911 Main St Salmon, ID 83467
(208) 756-2211

Today's Date: _____

First Name: _____ MI: ____ Last Name:_____ ❑ Male ❑ Female

Date of Birth:_____ Age: ____ Social Security #:_____

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (____)_____Work Phone:(_____)_____Cell Phone:(____)_____

Name of Spouse or Nearest Relative: _____ Phone: _____

Email Address: _____

Would you like to receive email appointment reminders? ❑Yes ❑No

Your Employer: _____

Would you like a copy of B.R.C. PLLC's Patient Privacy Regulations (HIPAA)? ❑Yes ❑No,
I do not wish to receive a copy although one has been offered to me. _____Initial

Referred to this Office by: ❑Friend/Family Member - Name? _____
❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other_____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card
❑Automobile Insurance ❑Worker's Compensation

MEDICAL/FAMILY HISTORY

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes.) S = Self M = Mother F = Father

	S	M	F		S	M	F		S	M	F
AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain	❑	❑	❑
anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness	❑	❑	❑
arthritis	❑	❑	❑	german measles	❑	❑	❑	numbness	❑	❑	❑
asthma	❑	❑	❑	headaches	❑	❑	❑	polio	❑	❑	❑
back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation	❑	❑	❑
bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis	❑	❑	❑
bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever	❑	❑	❑
cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism	❑	❑	❑
chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever	❑	❑	❑
concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury	❑	❑	❑
convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble	❑	❑	❑
diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	Stroke	❑	❑	❑
indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	tuberculosis	❑	❑	❑
								venereal disease	❑	❑	❑

Date of Last Physical Exam_____
Date of Last X-Ray_____ MRI_____ Reason_____

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No If so, describe condition_____

Have you ever had a metal implant? ❑Yes ❑No

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SURGICAL HISTORY:

1._____ Date: _____
2._____ Date: _____
3._____ Date: _____

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1._____Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your Symptoms (1-10, with 1 being least serious)

1._____ _____
2._____ _____
3._____ _____
4._____ _____
5._____ _____

WHEN AND HOW OCCURRED?_____
_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑ILLNESS
❑OTHER ACCIDENT ❑UNKNOWN CAUSE ❑GRADUAL ONSET
DATE OCCURRED:_____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES, When?_____

SYMPTOMS/COMPLAINTS: ❑ COME & GO ❑ARE CONSTANT ❑ARE NEARLY CONSTANT

SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT ❑Consistent

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____ _____
_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):_____
_____
_____

Your Occupation_____ (**Females only**) ARE YOU PREGNANT ❑YES ❑NO

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:

❑BENDING
❑REACHING
❑STRAINING AT STOOL
❑COUGHING
❑SITTING
❑TURNING HEAD
❑STANDING
❑LYING DOWN
❑WALKING
❑SNEEZING
❑LIFTING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

❑BENDING
❑SITTING
❑LIFTING
❑STANDING
❑WALKING
❑REACHING
❑TURNING HEAD
❑LYING DOWN

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PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

❑blurred vision
❑buzzing in ears
❑cold feet
❑cold hands
❑cold sweats
❑concentration loss /confusion
❑constipation
❑depression /weeping spells
❑diarrhea
❑dizziness
❑face flushed
❑fainting
❑fatigue
❑fever
❑head seems too heavy
❑headaches
❑insomnia
❑light bothers eyes
❑loss of balance
❑loss of smell
❑loss of taste
❑low resistance to colds
❑muscle jerking
❑numbness in fingers
❑numbness in toes
❑pins and needles in arms
❑pins and needles in legs
❑ringing in ears
❑shortness of breath
❑stiff neck
❑stomach upset

ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND? _____

_____

_____

By signing this consent for treatment, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I hereby give my consent to treatment.

Patient's Name: _____

Patient's Signature:_____Date:_____

Doctor's Signature: _____Date:_____

Signature of parent or guardian if patient is a minor: _____

We would like to extend you a very warm welcome to our office. Here at Bitterroot Regional Chiropractic we strive for excellence in patient care and hold ourselves to the highest standards of professionalism. We look forward to becoming an integral part of you and your family's healthcare.

Yours in Health,

Dr. Brian A. Barry