Welcome to the Pain Relief Center
Dr. Rik Wahlrab DC

Confidential Patient Health Record ***Today's Date*:____/____/_____**

Were you referred to us? If so, by whom? _____

Personal Information

Last:_____First:_____Middle:_____

Birth Date: ____ /____/_____ Age:_____ Sex: M / F

Address:

_____Apt# _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____-_____

Email Address: _____

Current Health Condition

What is the MAIN reason you are here today?_____

What other areas or concerns do you want us to address?

_____

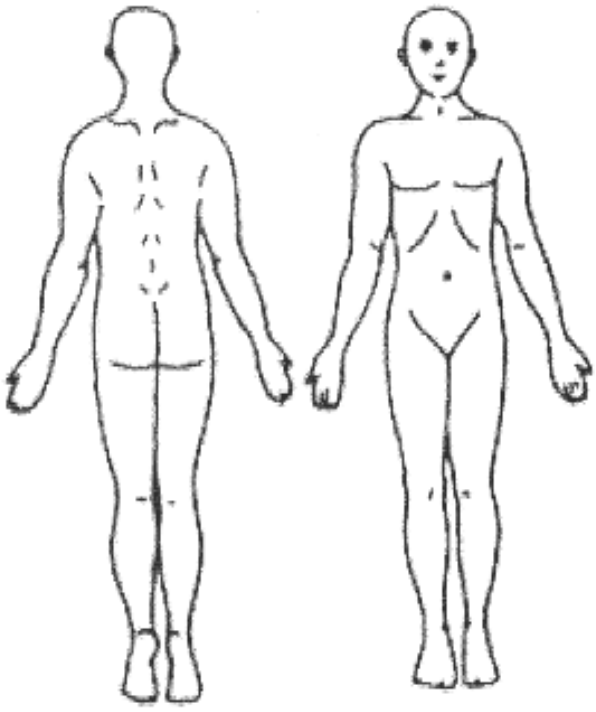
_____

Please indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? □ **Yes** □ **No When?** _____

Have you ever been to a Chiropractor? _____

….If so, how long ago was you last visit? _____

Is the Condition the result of a recent Accident?

□ **Auto Related** □ **Job Related** □ **Other**

Explain: _____

_____

Date of Accident: (If applicable) _____

Previous Care for Same Condition □ **I have not seen another doctor for this condition**

Who have you seen for this problem? (Name) _____

Type of Treatment: **Did it help?** □ **Yes** □ **No**

_____ **Explain:**

_____

Is there anything else regarding your health you want us to know about? Please describe:

_____

_____

I give permission for this information to be discussed with me

Patient's Signature: _____ **Date:** _____