

**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

Height ___ Weight ___

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? _____

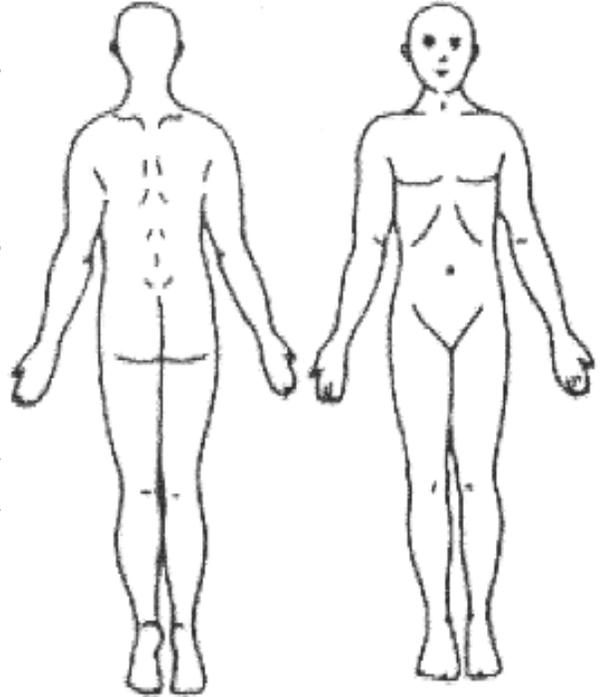
....If so, how long ago was you last visit? _____

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: _____