Visit us at boisedc.com to gain more insight of the services we offer.

Dr. Daniel Burkhart, BA, DC
1028 S. Vista Ave.
Boise, ID 83705

New Client Information

Today's Date: ___/____/_____

GENERAL INFORMATION

Name: _____ Date of Birth: ____/____/_____ Age: _____

SS#: _____-_____-_____

Address: _____ City: _____

State: _____ Zip Code: _____

Primary Phone #: _____ Secondary Phone #: _____

Email: _____ (please submit an actively used email address as this is our primary source of communication with our clients)

Marital Status: Single ____ Married ____ Divorced _____

Spouses Name: _____ Spouses Occupation/Employer _____

Number of Children: _____

Name and Phone Number of Emergency Contact: _____

Relationship to Client: _____

Reason for consulting our office today? _____

Who may we thank for referring you to our office? _____

EMPLOYMENT INFORMATION

Place of Employment: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone #: _____
Ext:_____ Website: _____

Job Description/Occupation: _____

In the space provided below, please describe daily activities/tasks required for your job.

Addressing The Issues That Brought You To Our Office

If you have no symptoms or complaints, and are here for wellness services, please(√) here___. Those here for wellness services may skip to "Your Health Profile".

Others need to briefly describe in detail the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, how would you describe it? (i.e. Sharp, Shooting, Dull, Ache, Deep)

_____

When did this condition begin? _____ Have you experienced a similar situation in the past? Yes No On a scale of 1-10, rate the severity of your condition _____ (10 = Worst)

Since the problem started, it is... □ About the same □ Getting better □ Getting Worse

What have you tried that makes it better? (i.e. Ice, Heat, Stretch, Rest)

_____

What seems to make it worse? (i.e. Walking, prolonged standing/sitting, physical activity)

_____

If you are experiencing pain, does it radiate to other areas of your body? Yes No
if Yes, then where?

_____

How often does this effect you? □ Daily/All Day □ Daily/Intermittent □ Weekly □ Monthly

Does it interfere with: □ Work □ Sleep □ Daily Activities □ Hobbies

Other health care practitioners seen for this problem. _____

Please check (√) all symptoms you have ever had, even if they do not seem related to your current

□	Neck pain or stiffness	□	Fainting	□	Pain, tingling or numbness in legs
□	Headaches	□	Mid back pain	□	Low back pain
□	Ringing in the ears	□	Loss of taste	□	Excessive gas and/or bloating
□	Sinus/allergy problems	□	Cold hands	□	Loss of smell
□	Blurring of vision	□	Fever	□	Cold feet
□	Loss of balance	□	Problem urinating	□	Numbness in toes
□	Pain, tingling or numbness in arms	□	Menstrual irregularity	□	Light sensitivity
□	Dizziness	□	Digestive problems	□	Diarrhea
□	Numbness in fingers	□	Heartburn	□	Cold sweats
□	Fatigue	□	Tension	□	Mood swings
□	Sleeping problems	□	Nervousness	□	Depression
□	Irritability	□	Stomach pain	□	Heart problems

Your Health Profile

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (birth to age 17)

Did you have any childhood illnesses?	Yes	No	Unsure
Did you have any serious falls as a child?	Yes	No	Unsure
Did you play youth sports?	Yes	No	Unsure
Did you take/use any drugs?	Yes	No	Unsure
Did you have any surgeries?	Yes	No	Unsure
Have you fallen/jumped from a height over three feet?	Yes	No	Unsure
Were you involved in any car accidents as a child?	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No	Unsure
Did you suffer any other traumas (physical and/or emotional)?	Yes	No	Unsure
As a child, were you under regular Chiropractic Care?	Yes	No	Unsure

Additional Comments _____

_____

ADULT—(18 to present)

Do/did you smoke?	Yes	No
Do/did you drink alcohol	Yes	No
Have you been in any accidents?	Yes	No
Have you had any surgery?	Yes	No

Do/did you play any adult sports?

On a scale of 1 –10 describe you stress level:
(1 = none / 10 = Extreme)

Occupational _____

Personal _____

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

Diet _____ Exercise _____

Sleep _____ General Health _____

The statements made on these forms are accurate to the best of my recollection and I agree to a thorough examination for further evaluation. I understand that I am financially responsible for all charges whether or not paid by any third-party payor. I hereby authorize this office to release all information necessary to obtain payment of benefits. Also, I authorize the use of this signature on all insurance forms.

Signature _____ Date _____