Bruns Chiropractic Clinic
Richard M. Bruns, D.C.
371 Union Street Bangor, ME 04401
Tel (207) 947-1199 Fax (207) 942-8729

DATE: _____

Patient's Name: _____ **DOB:** _____ **Gender:** ___ **ID#:** _____

Personal Health History:

Have you had any recent surgeries: ☐ NO ☐ Yes, _____

Have you had any recent illnesses: ☐ NO ☐ Yes, _____

Have you had any recent hospitalizations: ☐ NO ☐ Yes, _____

Have you been diagnosed with any conditions, illnesses, diseases in the past? : ☐ NO ☐ Yes, _____

_____

Have you suffered any significant injuries, traumas or falls in the past? ☐ NO ☐ Yes, _____

_____

Have you had any recent medical tests? ☐ NO ☐ Yes, ☐ X-ray ☐ Cat Scan ☐ MRI ☐ PET Scan

☐ Bone Scan/Osteoporosis ☐ EMG ☐ Urine Test ☐ Blood Work ☐ _____

Do you have any allergies or reactions to medications? ☐ NO ☐ YES, _____

Do you have any food or environmental allergies? ☐ NO ☐ YES, _____

Do you have a PACEMAKER? ☐ NO ☐ YES, _____

Have you been diagnosed with DIABETES? ☐ NO YES, ☐ Type 1 ☐ Type 2

Have you been diagnosed with HYPERTENSION? ☐ NO ☐ YES Are you under supervision? ☐ NO ☐ YES

Have you been diagnosed with high cholesterol? ☐ NO ☐ YES Are you under supervision? ☐ NO ☐ YES

Female Patient's Only:

Are you currently or possibly pregnant? ☐ NO ☐ YES

Are you currently taking Hormone Replacement therapy? ☐ NO ☐ YES

Are you using birth control medication? ☐ NO ☐ YES

Social, Lifestyle History and Habits:

a. Alcohol Use? ☐ None ☐ Light ☐ Moderate ☐ Heavy

b. Caffeinated Beverages? ☐ None ☐ < 3 ☐ 3-6 ☐ > 6 /Day

c. Tobacco Use? ☐ Never Smoked ☐ Former Smoker ☐ Current Every Day Smoker - __ Light __ Heavy

d. Exercise? ☐ None ☐ Light Exercise ☐ Moderate Exercise ☐ Intense Exercise __ Walking __ Running

e. __ Aerobics __ Gym __ Yoga __ Calisthenics __ Biking __ Swims __ Other: _____

Family Health History: List any Illness, Disease or Condition by family member.

(i.e. Stroke, Heart Disease, Osteoporosis, Cancer (type), Hypertension, Diabetes, Kidney Disease)

1. **Mother:** ☐ Unremarkable ☐ She had, ___ Heart disease ___ Hypertension ___ Osteoporosis ___ Diabetes ___ Kidney Disease ___ Fibromyalgia Other, _____ Deceased from: _____ in _____
2. **Father:** ☐ Unremarkable ☐ He had, ☐ Heart disease ___ Hypertension ___ Osteoporosis ___ Diabetes ___ Kidney Disease ___ Fibromyalgia Other, _____ Deceased from: _____ in _____
3. **Sibling:** ☐ Unremarkable ☐ He/She had _____
4. **Sibling** ☐ Unremarkable ☐ He/She had _____

I have reviewed the patient history completed above and I attest it is accurate to the best of my knowledge.

PATIENT/GUARDIAN Signature: X _____ **Date:** _____

Bruns Chiropractic Clinic
Richard M. Bruns, D.C.
371 Union Street Bangor, ME 04401
Tel (207) 947-1199 Fax (207) 942-8729

DATE: _____

Patient's Name: **DOB:** **Gender:** **ID#:**

Symptom History:

When did your symptoms begin? (Most recent episode): _____

What do you think may have caused your symptoms? ☐ Slip/Fall ☐ Trip ☐ Sports Injury ☐ Illness

☐ Lifting _____ ☐ Traveling ☐ Prolonged Sitting ☐ _____

How did your symptoms start? ☐ suddenly ☐ gradually over the past _____ Days ____ Weeks ____ Months

Where were you when your symptoms began? _____

Are your symptoms changing with time? ☐ Worse ☐ Same ☐ Improving

Prior Interventions: Have you seen any other providers for your symptoms? __ No __ Yes

☐ ER/Walk-in Care: _____ Treatment: _____
☐ Chiropractor, Dr. _____ Treatment: _____
☐ Medical Dr., _____ Treatment: _____
☐ Physical Therapist, _____ Treatment: _____
☐ _____ Treatment: _____

Treatment Results: ☐ Better ☐ No Change ☐ Worse _____

Dr.'s Notes: _____

Relieving Factors: Is there anything that makes your symptoms feel better? ☐No ☐Yes

☐Applying Cold ☐ Applying Heat ☐ Changing Position ☐ Rest ☐ Medication (Type)_____
☐Massage ☐Sitting☐Standing ☐ Laying down ☐ Other_____

Aggravating Factors: Is there anything that makes your symptoms feel worse? ☐ No ☐ Yes

☐ Lifting ☐ Driving ☐ Stairs ☐ Work Activities ☐ Standing ☐ Sitting ☐ Bending ☐ Movement
☐ Walking ☐ Getting in and out of vehicle ☐ Arising from a chair ☐ Getting in and out of bed

_____

Dr.'s Notes: _____

Medications: Are you taking any prescription medications? ☐ None ☐ Yes, I am Taking:

a. _____ Dose: _____ b. _____ Dose: _____
b. _____ Dose: _____ h. _____ Dose: _____
c. _____ Dose: _____ i. _____ Dose: _____

☐ List Provided - Refer to scanned list in EHR

Have there been any changes with your medications? ☐ No ☐ Yes _____

Are you taking any over the counter medications? ☐ No ☐ Yes _____

Dr.'s Notes: _____

_____