



# Burland Chiropractic

Dr. Brandi Burland  
Chiropractic Physician

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## PATIENT HISTORY

*If a Minor (under 18 years old), Name and Address of responsible parent/guardian:*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Status: Married Single Other \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Current Conditions/ Problems: \_\_\_\_\_

When did this condition occur: \_\_\_\_\_

Is condition:  Job Related  Auto Related  Home Injury  Fall  Other: \_\_\_\_\_

Please describe what happened:

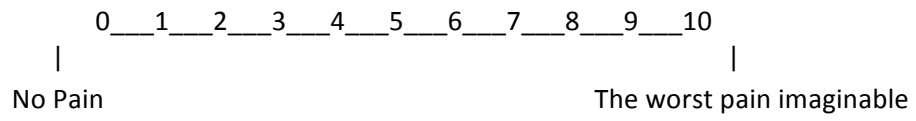
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you received chiropractic care before:  No  Yes, Who: \_\_\_\_\_

Do you have a primary care physician:  No  Yes, Who: \_\_\_\_\_

(Please turn over)

Please rate your level of discomfort at the moment:



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Please use the diagram to describe your symptoms and mark the exact location:

