

ABOUT THE PATIENT

Name: _____ Today's Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ E-Mail Address: _____
 Height: _____ Weight: _____ Gender: M F _____ Birthdate: ___ / ___ / ___ Age: _____
 Our aim is to create a safe environment for our members and their families, is there anything you'd like to specifically and explicitly let us know? _____
 Single / Married / Widowed / Partnered – Name: _____
 Number of Children: _____ Names and Ages: _____
 Who may we thank for referring you in? _____ Have you ever been to a chiropractor before? No Yes
 Your Employer: _____ Type of Work: _____
 Emergency Contact: _____ Phone #: _____
 Name of Medical Doctor(s): _____

- I authorize the doctor(s) or staff to render care as deemed appropriate for me and / or my child.
- I authorize **King Chiropractic** to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: Cash Check Credit Card Car/Work Ins.

 Patient Signature (this represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb/Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____

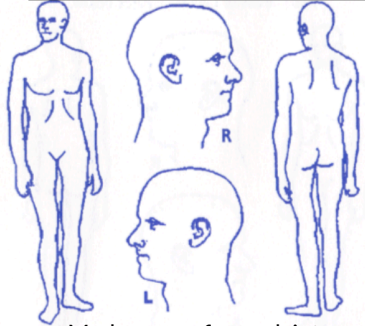
7. What makes it worse? _____

8. What Doctor's have been seen for this? (if so who and when): _____

9. Type of treatment: _____

10. Results: _____

NOTES: _____



Mark areas of complaint

GENERAL HEALTH HISTORY

Patient Name: _____ *Mark the conditions that apply to you.*

Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Allergies / Asthma	<input type="checkbox"/>	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Blood Pressure <input type="checkbox"/> High or <input type="checkbox"/> Low
<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Liver Problems
<input type="checkbox"/>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/> Stroke History	<input type="checkbox"/>	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/>	<input type="checkbox"/> Ear Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV
<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> Muscle Aches
<input type="checkbox"/>	<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/>	<input type="checkbox"/> Trouble Walking
<input type="checkbox"/>	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/> Tension / Irritability
<input type="checkbox"/>	<input type="checkbox"/> Seizures	<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/> Leg / Foot Numbness
<input type="checkbox"/>	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/> Infertility
<input type="checkbox"/>	<input type="checkbox"/> Dental Problems / Surgeries	<input type="checkbox"/>	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/> TMJ - Jaw Pain / Clicking	<input type="checkbox"/>	<input type="checkbox"/> Blood Thinner Use
<input type="checkbox"/>	<input type="checkbox"/> Vision Problems	<input type="checkbox"/>	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/>	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/> Hands or Feet Cold
<input type="checkbox"/>	<input type="checkbox"/> Medication Side Effects	<input type="checkbox"/>	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/>	<input type="checkbox"/> Alcohol Use - Amount/week: _____	<input type="checkbox"/>	<input type="checkbox"/> Replacements <input type="checkbox"/> Hip or <input type="checkbox"/> Knee
<input type="checkbox"/>	<input type="checkbox"/> Tobacco Use - Amount/week: _____	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Cancer - Type / Remission: _____		

2. Please list ALL DOCTORS you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor." No Yes - Name: _____

PAST NON-PREGNANCY RELATED HISTORY

4. List any past auto collisions/dates: _____ **Was any care received?** _____

5. List any past work injuries/dates: _____ **Was any care received?** _____

6. List any past sport, recreational, or home injuries: _____

7. Have you ever been knocked unconscious? No Yes **8. Fractured any bones?** No Yes

9. Have you had any spinal x-rays / MRI's / CT's taken in the last year? If so, where? _____

10. Please list HOSPITALIZATIONS and SURGERIES (if any) and dates: _____

11. Any other bodily trauma: _____

FAMILY HISTORY

Father's Side: Heart Disease Cancer Diabetes Heavy Medication Use Arthritis Other _____

Mother's Side: Heart Disease Cancer Diabetes Heavy Medication Use Arthritis Other _____

Any known difficulties with your mothers pregnancy? _____

Is there any other family history you want us to know? _____

PREGNANCY AND FERTILITY HISTORY

Any fertility issues / treatments?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain: _____
Do you smoke?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many / week? _____
Do you drink?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many / week? _____
Do you exercise?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain: _____
Any illnesses during pregnancy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain: _____
Any ultrasounds?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain: _____
Previous birth control use?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please list duration and type: _____ Please indicate age first started: _____

CHILDBIRTH CARE GIVERS (please list)

OB/GYN: _____
Midwife: _____
Doula: _____
Birth Coach/Educator: _____
Other team member: _____
Number of previous pregnancies: ___ Number of deliveries: _____
Please explain any difference in the numbers: _____
Please explain any other concerns or notable remarks about your child's conception or pregnancy: _____

Any complications in previous pregnancies or deliveries? _____

Any notable episodes of mental or physical stress during your pregnancy? _____

What are your expectations with care at King Chiropractic? _____

