

ABOUT YOU

Today's Date: _____ Name: _____
What you prefer to be called: _____ Male Female Age: _____
Birthdate: _____ SS# _____
Home Address: _____ City _____ State _____ Zip _____
Home Phone #: _____ Cell # _____
Employer &
Address: _____
Occupation: _____ Work # _____
Marital status: single married divorced widowed Spouse's Name: _____
E-Mail _____ Referred by: _____

REASON FOR VISIT

Have you ever been to a Chiropractor before: Yes No Name of
Chiro: _____
If so, explain _____
Reason for this visit: work auto trauma other
explain: _____

Describe pain and
location: _____

When did condition begin? _____ / _____ / _____
Is the condition getting worse? yes no constant comes and goes
Is the condition interfering with: work sleep daily routine
explain: _____
Have you been treated by medical doctor for this condition? yes no
If so, where: _____
Who is your general practitioner _____

HEALTH HISTORY

Are you taking any of the following medications? nerve pills pain killers (including aspirin)
 muscle relaxers blood thinners insulin
other _____
Have you ever had any of the following diseases/medical conditions(s)?

<input type="radio"/> heart attack	<input type="radio"/> heart surg/pacemaker	<input type="radio"/> heart murmur	<input type="radio"/> arthritis
<input type="radio"/> mitral valve prolapse	<input type="radio"/> artificial valves	<input type="radio"/> alcohol/ drug abuse	<input type="radio"/> venereal disease
<input type="radio"/> hepatitis	<input type="radio"/> HIV / AIDS	<input type="radio"/> shingles	<input type="radio"/> cancer
<input type="radio"/> Emphysema	<input type="radio"/> anemia	<input type="radio"/> high/low blood pressure	<input type="radio"/> psychiatric problems
<input type="radio"/> Kidney problems	<input type="radio"/> diabetes	<input type="radio"/> fainting/ seizures/ epilepsy	<input type="radio"/> artificial bones/ joints

List any other conditions you have had: _____
List any surgeries: _____
List anything that you may be allergic to: _____
Do you smoke? yes no Are you pregnant? _____

Today's date ____ / ____ / ____

Name: _____

WORK RELATED INJURY

Date & Time of Accident: _____ O am O pm

Briefly describe the events that occurred during your accident _____

Who is your employer _____

Did you report the accident to your employer? O yes O no

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ O am O pm

Were you the: O driver O front passenger O rear passenger

● Was a ticket issued? O yes O no

● Was a police report filed? O yes O no

● Were you wearing a seat belt? O yes O no

● Did airbags inflate? O yes O no

What did your vehicle impact? _____

Make, model & speed of vehicle you were in: _____

Name of street you were traveling on: _____

Please describe accident: _____

AFTER INJURY

Did you go to the hospital? O yes O no

When did you go? O just after O the next day O 2 days plus

How did you get there? O ambulance O private transportation

Name of hospital: _____

Describe any treatment: _____

Have you been seen by another doctor for this injury? O yes O no

If yes, whom: _____

Were X-rays taken? O yes O no

Was medication prescribed? O yes O no

Have you been able to work since injury? O yes O no

Describe the pain you are having as a result of accident: _____

Have you retained an attorney? O yes O no

If yes, whom: _____

His/Her phone #: _____

Signature _____

Date ____ / ____ / ____

PAIN CHART

Name: _____

Use the letters to indicate the type of pain you are having NOW

A= Ache

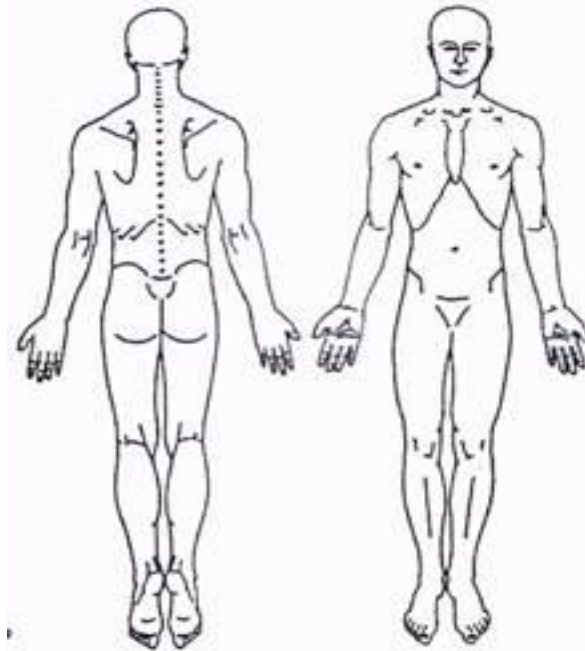
P= Pins and Needles

B= Burning

S= Stabbing

N= Numbness

O= Other



- We invite you to discuss with us any questions regarding our services.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims as well as to other health care providers.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

K & S CHIROPRACTIC, LLC Signature _____ Date _____