KINNI VALLEY CHIROPRACTIC

Patient Name _____ **Date of Birth** _____

Patient Address _____

_____ **Male or Female** (please circle one)

Home Phone _____ **Cell** _____

SSN _____ **Date of Initial Consultation** _____

(please circle) Work Comp. Personal Injury Motor Vehicle Accident Health Insurance Cash

Diagnosis 1._____ **2.**_____ **3.**_____ **4.**_____

5._____ **6.**_____ **7.**_____ **8.**_____

Date of Injury _____

Primary Insurance _____

Insurance Company Address _____

_____

Name of Insured _____ **D.O.B.**_____ **SSN**_____

Relationship to Insured: (please circle) Self Spouse Child Unknown

Policy/ID Number _____ **Claim/Group Number** _____

Adjusters Name _____ **Adjuster Phone** _____

Secondary Insurance Name _____ **Policy/ID Number** _____

Group Number _____ **Name of Insured** _____

Relationship to Insured: (please circle) Self Spouse Child Unknown

Attorney Name/Address/Phone _____

_____

_____

PATIENT CONDITION

Describe your major complaint(s): _____

_____

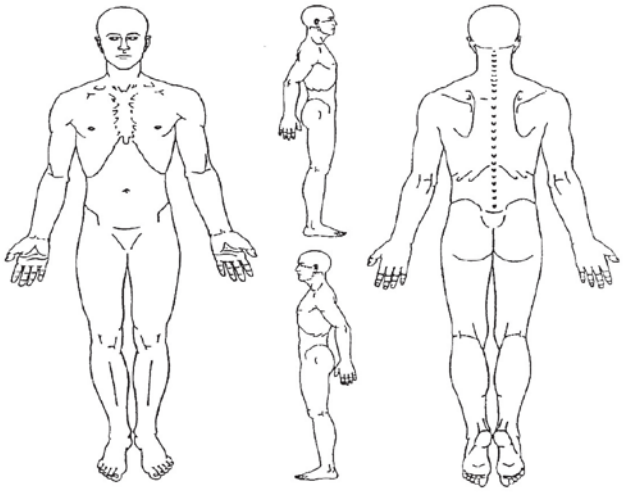
Date you first noticed symptoms: _____ Describe when they began: _____

_____

Have you had these symptoms before: ☐YES ☐NO If yes, when:_____

How often do you experience these symptoms?

- ☐ Constantly (76%-100% of the day)
- ☐ Frequently (51%-75% of the day)
- ☐ Occasionally (26%-50% of the day)
- ☐ Intermittently (0%-25% of the day)



How would you describe the symptoms?

☐ Sharp	☐ Shooting	☐ Stabbing	☐ Weakness
☐ Dull	☐ Burning	☐ Stiffness	☐ Throbbing
☐ Numb	☐ Tingling	☐ Cramps	☐ Achy

How are your symptoms changing?

☐ Getting Better ☐ Getting Worse ☐ No Change

How would you rate your symptoms at their:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Complaints	Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible	

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you seen any other health care professionals for this condition? ☐ YES ☐ NO If yes, list providers:

Name Address Date

_____

_____

Have you had any test done for your symptoms? ☐ YES ☐ NO If yes, please check and give dates

☐X-Rays _____ ☐CT Scan_____ ☐MRI_____ ☐Lab_____ ☐Other_____

Please indicate findings if known: _____

Have you ever received chiropractic care before? ☐ YES ☐ NO If yes, please list:

Name Address Date

_____

_____

HEALTH HISTORY

Place a mark on the box to indicate if you have had any of the following:

☐Headaches	☐Numbness	☐Shingles
☐Migraines	☐Heart Attack	☐Hepatitis
☐Congenital Heart Defect	☐Stroke	☐Kidney Problems
☐Pacemaker	☐Alcohol/Drug Abuse	☐Cancer
☐Heart Murmur	☐Venereal Disease	☐Anemia
☐High/Low Blood Pressure	☐HIV/Aids	☐Eating Disorder
☐Difficulty Breathing	☐Diabetes	☐Thyroid Problems
☐Asthma	☐Tuberculosis	☐Smoker
☐Arthritis	☐Shingles	☐Psychiatric Problems
☐Dizziness	☐Hepatitis	☐Chemotherapy

EXERCISE	WORK ACTIVITY	HABITS
☐None	☐Sitting	☐Smoke Packs/Day_____
☐Moderate	☐Standing	☐Alcohol Drinks/Week_____
☐Daily	☐Light Labor	☐Caffeine Drinks/Week_____

MEDICATIONS (PLEASE LIST ALL INCLUDING BIRTH CONTROLS, VITAMINS AND SUPPLEMENTS)

_____

_____

_____

GOALS FOR CARE

☐ **Relief Care-** relieving the pain or discomfort

☐ **Corrective Care**- Correcting the root of the problem and elimination of pain/discomfort

☐ **Wellness Care**- Bringing whatever is malfunctioning in the body to its highest state of health

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that…

…Doctors of Chiropractic work with the nervous system?

…the nervous system controls all bodily functions and systems?

…Chiropractic is the largest natural healing profession in the world?

…if Chiropractic care starts at birth, you can achieve a higher level of healing throughout life?