Date: ______________
Patient # ______________

CONFIDENTIAL PATIENT HISTORY

Last ______________ First ______________ Middle Initial ______ Birth Date ______________ Age ______
Address ______________ City ______________ ST ________ Zip ______________
Phone (H) ______________ (W) ______________ (C) ______________
Email ______________ May we send you our online newsletter? ☐yes ☐no
Occupation ______________ Employer ______________
Spouse's Name ______________ D.O.B ______________ Spouse Ph ______________ Employer ______________
Children's Name & Ages ______________
Have you had previous Chiropractic care? ☐yes ☐no Whom? ______________
Who may we thank for referring you to our office? ______________ ☐Walk In ☐Advertisement ☐Promotion ☐Yellow Pages
Who is your primary care physician? ______________ Address: ______________
Phone: ______________ Date of last physical/exam? ______________ With Whom? ______________
When doctors work together, it benefits you. May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

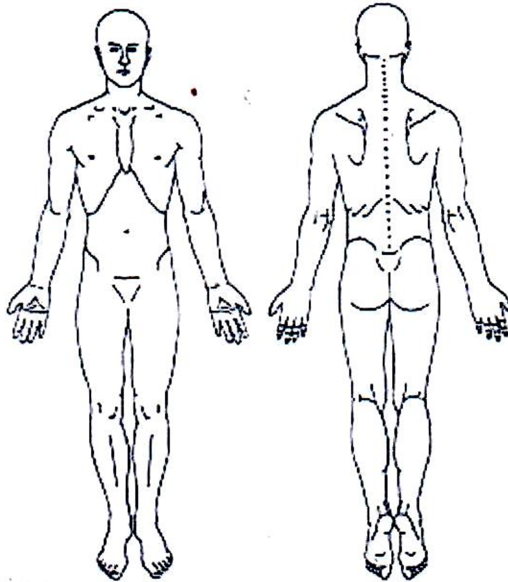
WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: ______________
Date when symptom first appeared ______________ How Did it begin: ______________
How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%
Have you ever experienced the same or similar symptoms? ☐yes ☐no When? ______________
Have you been to another doctor for this problem? ☐yes ☐no Who/Where? ______________
Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? ______________
Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other ______________ ☐Does not radiate
What makes the symptoms increase? ______________ What relieves the symptoms? ______________
Drugs you now take: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other: ______________
Do any family members suffer from the same complaint? If so, who? ______________

SECONDARY COMPLAINT: ______________
Date when symptom first appeared ______________ How Did it begin: ______________
How often do you experience these symptoms? ☐Constant 100% ☐Frequent 75% ☐Intermittent 50% ☐Occasional 25% ☐Rare10%
Have you ever experienced the same or similar symptoms ☐yes ☐no When? ______________
Have you been to another doctor for this problem? ☐yes ☐no Who/Where? ______________
Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other Do you have Numbness or Tingling? ☐yes ☐no Where? ______________
Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other ______________ ☐Does not radiate
What makes the symptoms increase? ______________ What relieves the symptoms? ______________

Age of Mattress ______________ ☐Comfortable ☐Uncomfortable
Have you ever been in an auto accident? ☐Past Year ☐Past 5 Years ☐Over 5 Years ☐Never
Please describe: ______________
Please list all surgeries, injuries, accidents, falls, etc: ______________

Please mark off all areas of complaint on the diagrams with the following indicators:
AAA=ache
DDD=dull
NNN = numbness
TTT= tingling
BBB= burning
SSS=sharp/stabbing
XXX = other



Please list any medications or vitamins you are currently taking (including dosage).

____
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____
____
____
____
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Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms. 10 being extreme)

0 ◇◇◇ 1 ◇◇◇ 2 ◇◇◇ 3 ◇◇◇ 4 ◇◇◇ 5 ◇◇◇ 6 ◇◇◇ 7 ◇◇◇ 8 ◇◇◇ 9 ◇◇◇ 10

Do you smoke? ☐yes ☐no If yes, how many packs per week? ____ **Have you ever smoked in the past?** ☐yes ☐no When did you quit? ________
Do you consume alcohol? ☐yes ☐no If yes, how many drinks per week? ________
Do you consume caffeine? ☐yes ☐no If yes, how many drinks per day? ________
Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ________
Do you have a high stress level? ☐yes ☐no If yes, list reasons: ________

Is there any possibility that you may be pregnant? ☐yes ☐no **Date of Last Menstrual Cycle** ________

Please check if you have had any of the following:

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Arthritis	☐ Disc Degeneration	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Problems
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems
☐ Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Klein Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Klein Chiropractic Clinic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: ______________________ Date: ________

Guardian's Signature: ______________________ Date: ________