

# Welcome to Dr. Connie's Chiropractic & Wellness Center

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

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

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

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

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

Date of Birth: \_\_\_\_\_ I am  married;  single;  divorced;  widowed;  adopted

Spouse/Partner's Name: \_\_\_\_\_ I am  female;  male

Referred by:  Friend/Family: name \_\_\_\_\_;  Internet;  Insurance;  Yellow Pages



Please **initial** the contact options you prefer, giving Dr. Connie your permission to contact you in that way.

May call my **home phone** number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This is my **preferred number**.  You may leave a message on my home voicemail.

May leave a message with the person that answers this phone.

May call my **cell phone** number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This is my **preferred number**.  You may leave a message on my cell voicemail.

May leave a message with the person that answers this phone.

May send **text appointment reminders** to my cell phone.

**My cell phone PROVIDER** is: \_\_\_\_\_

May call my **work phone** number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This is my **preferred number**.  You may leave a message on my work voicemail.

May leave a message with the person that answers this phone.

May **email appointment reminders** to my email address (in section above).

Yes, I want to receive Dr. Connie's electronic monthly newsletter to my email address.

Payment for services will by:  Self;  Health Insurance;  Auto Insurance;  Other

Insurance Company \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Is the patient covered by more than one insurance company?  Yes  No

Name of secondary insurance company: \_\_\_\_\_

Name of Insured (if different from patient's): \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Have you ever been to a chiropractor before?  Yes  No

If yes, have you ever had a bad reaction to an adjustment?  Yes  No

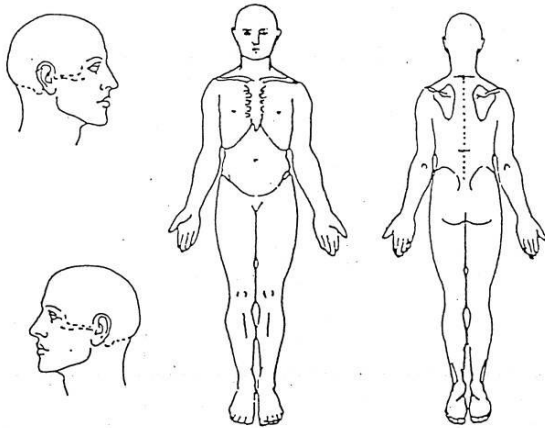
Have you had any auto or other accident?  Yes  No Date: \_\_\_\_\_

Describe: \_\_\_\_\_

Dr. Connie's Chiropractic Center – 7700 Shawnee Mission Parkway, Suite 211, Overland Park, KS 66202

913-384-5423 [www.drconnies.com](http://www.drconnies.com)

**Please Mark Your Areas Of Pain On The Diagrams Below:**



- Main reason for consulting our office:
- Become pain free
  - Explanation of my condition(s)
  - Learn how to care for my condition(s)
  - Reduce my symptoms
  - Resume normal activity level

What is your **major** complaint? \_\_\_\_\_

Date problem began? \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

Condition is on  the Right Side  the Left Side  Both Sides

Have you had this condition in the past?  Yes  No

Please rate your pain on a scale of 1-10 (0 = no pain and 10 = excruciating pain)

1  2  3  4  5  6  7  8  9  10

How is your condition changing?  None  Same  % Better  % Worse

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect / 10 = all activities affected)  1  2  3  4  5  6  7  8  9  10

What is the intensity of your symptoms:

Minimum  Mild  Moderate  Severe  Unbearable  None

What is the nature of your symptoms:

Burning  Dull  Numb  Radiating  Sharp  Shooting  Stabbing

Tight(ness)  Tingling  Throbbing

Other \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc)? \_\_\_\_\_

How often do you experience you symptoms?

Constantly (76 - 100% of the day)

Frequently (51 - 75% of the day)

Occasionally (50 - 26% of the day)

Intermittently ( 0 - 25% of the day)

What activities aggravate your condition (working, exercise, etc.)? \_\_\_\_\_

What is your **second** complaint? \_\_\_\_\_ Date problem began? \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

Condition is on \_\_\_ the Right Side \_\_\_ the Left Side \_\_\_ Both Sides

Have you had this condition in the past? \_\_\_ Yes \_\_\_ No

Please rate your pain on a scale of 1-10 (0 = no pain and 10 = excruciating pain)

\_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10

How is your condition changing? \_\_\_ None \_\_\_ Same \_\_\_ % Better \_\_\_ % Worse

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect / 10 = no possible activities) \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_6 \_\_\_7 \_\_\_8 \_\_\_9 \_\_\_10

What is the intensity of your symptoms:

\_\_\_ Minimum \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_ Unbearable \_\_\_ None

What is the nature of your symptoms: \_\_\_ Burning \_\_\_ Dull \_\_\_ Numb \_\_\_ Radiating \_\_\_ Sharp

\_\_\_ Shooting \_\_\_ Stabbing \_\_\_ Tight(ness) \_\_\_ Tingling \_\_\_ Throbbing

\_\_\_ Other \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc.)? \_\_\_\_\_

How often do you experience your symptoms?

\_\_\_ Constantly (76 - 100% of the day) \_\_\_ Frequently (51 - 75% of the day)

\_\_\_ Occasionally (50 - 26% of the day) \_\_\_ Intermittently ( 0 - 25% of the day)

What activities aggravate your condition (working, exercise, etc.)? \_\_\_\_\_

\*\*\*\*\*

What is your **next** complaint? \_\_\_\_\_ Date problem began? \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

Condition is on \_\_\_ the Right Side \_\_\_ the Left Side \_\_\_ Both Sides

Have you had this condition in the past? \_\_\_ Yes \_\_\_ No

Please rate your pain on a scale of 1-10 (0 = no pain and 10 = excruciating pain)

\_\_\_ 1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5 \_\_\_ 6 \_\_\_ 7 \_\_\_ 8 \_\_\_ 9 \_\_\_ 10

How is your condition changing? \_\_\_ None \_\_\_ Same \_\_\_ % Better \_\_\_ % Worse

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect / 10 = no possible activities) \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_6 \_\_\_7 \_\_\_8 \_\_\_9 \_\_\_10

What is the intensity of your symptoms:

\_\_\_ Minimum \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_ Unbearable \_\_\_ None

What is the nature of your symptoms: \_\_\_ Burning \_\_\_ Dull \_\_\_ Numb \_\_\_ Radiating \_\_\_ Sharp

\_\_\_ Shooting \_\_\_ Stabbing \_\_\_ Tight(ness) \_\_\_ Tingling \_\_\_ Throbbing

\_\_\_ Other \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc.)? \_\_\_\_\_

How often do you experience your symptoms?

\_\_\_ Constantly (76 - 100% of the day) \_\_\_ Frequently (51 - 75% of the day)

\_\_\_ Occasionally (50 - 26% of the day) \_\_\_ Intermittently ( 0 - 25% of the day)

Dr. Connie's Chiropractic Center – 7700 Shawnee Mission Parkway, Suite 211, Overland Park, KS 66202

913-384-5423 [www.drconnies.com](http://www.drconnies.com)

What activities aggravate your condition (working, exercise, etc.)? \_\_\_\_\_

**Medical/ Family History      S = Self      M - Mother      F = Father**

Please indicate which conditions have been experienced by you and/or your parents by marking the appropriate boxes. \*Note; if you are adopted please mark conditions of your birth parents only - if known.

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adopted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive disorders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain				

Do you have any allergies? Seasonal Foods? Plants? Materials? Scents?  
\_\_\_\_\_

**Surgical History**

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_

List medications you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any metal implants?     No     Yes                      Where: \_\_\_\_\_  
Do you have any breast implants?     No     Yes                      Where: \_\_\_\_\_  
Have you ever been gunshot?         No     Yes                      Where: \_\_\_\_\_

**In case of an emergency, please notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_