Krieg CHIROPRACTIC CENTER, INC.
You . . . Just More Extraordinary

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name: **Date:**	
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**E mail address:**
Best time/place to contact you:	**Social Security number:**
Date of birth:	**Age:**
No. of children: **Age(s):**	**Pregnant?** **Yes** ☐ **No** ☐
Height:	**Weight:**
Marital status: **M** **S** **W** **D**	**Emergency Contact (name and #):**
Occupation:	
Employer's name & address:	
Spouse/guardian name:	**Spouse's Occupation/Employer:**
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? **Yes** ☐ **No** ☐	**Do you have Medicare coverage?** **Yes** ☐ **No** ☐
Is this appointment related to: (circle one) work injury auto injury other_____	
When did the incident occur? **Attorney:**_____ **Phone:**_____	

Who may we thank for referring you? _____

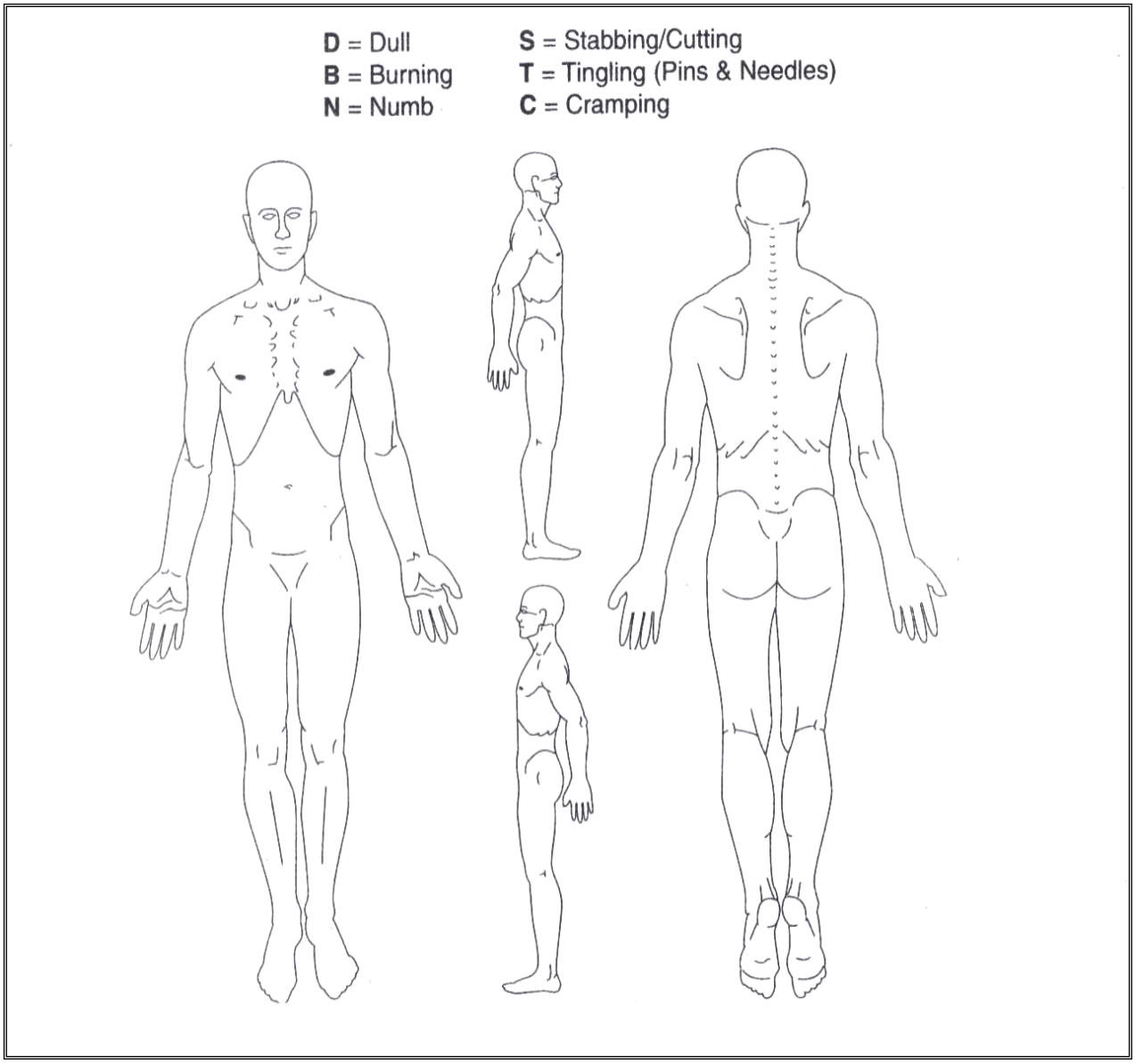
Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Wellness Care, please skip to the **"General Health History"**.*

Health Concerns (Please fill in the boxes according to what brought you here.)

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Use the letters shown to represent the type(s) and location(s) of discomfort.



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you are having right **now**:

No Pain — Unbearable

Rate the pain at its **best** in the past week:

No Pain — Unbearable

Rate your **average** pain in the past week:

No Pain — Unbearable

Rate your **worst** pain in the past week:

No Pain — Unbearable

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

_____

I do (do not) have a family history of this or similar symptoms (Please explain):

_____

Which activities aggravate your condition? _____

_____

Other health care providers you have seen for this condition:

General Chiropractor (uses various techniques that usually involve a twisting or manipulation of the neck and back)	☐
Upper Cervical Chiropractor (uses one of a several low force techniques that focuses on the upper neck to create better long term stability throughout the entire spine)	☐
Medical Doctor	☐
Massage Therapist	☐
Other (please describe)	☐

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

Are you interested in knowing more about how fitness and nutrition affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐

Past Health History

Please mark the following conditions you may have had or have now (- have had / + have now):

☐ Arm Pain	☐ Allergy	☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Leg Pain	☐ Low Blood Sugar	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Nerve Pain
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Vertigo (Dizziness)

Other (please explain) _____

Growth and Development (Please circle any answer that is appropriate for you.)

Birth Process: (relating to yours or your children's birth, please specify)

Was the delivery long? Yes No	Was the delivery difficult? Yes No
Was your mother given drugs during delivery? Yes No	Was labor induced? Yes No
Were you delivered at: Home Hospital Other_____	Was the delivery: Caesarean Vaginal Forceps Breach/Cephalic

Stressors *Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!* Because accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

1. **Physical stress** (falls, accidents, work postures, daily activities, etc.)
   a. _____
   b. _____
   c. _____
2. **Bio-chemical stress** (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, toxins at work, etc.)
   a. _____
   b. _____
   c. _____

3. **Psychological or mental/emotional stress** (work, relationships, loss, finances, self-esteem, death of a loved one, etc.)

   a. _____

   b. _____

   c. _____

On a scale of 1-10 (1 being minimal to none and 10 being extreme) please grade your present levels of stress (including physical, bio-chemical and mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

Do we have your permission to email you a summary of your **Report of Findings** for you to review at home? Yes ☐ No ☐

In general when it comes to my health I am more driven by my need to (please circle one)…

Avoid Pain and Loss or **be Preventative in Nature**.

Is there anything else which would help us understand you better that has not yet been discussed?

_____

What are you looking for most in a doctor?

_____

Print Patient Name: _____ Date: _____

Signature: _____