Welcome To Our Office!

Chiropractic, Plain & Simple, PLC

Kevin R. Krieger, DC · 3641 Bahia Vista Street, Sarasota, FL 34233 · 941.331.4334

Your First Consultation

CONFIDENTIAL PATIENT INFORMATION

First, Middle & Last Name: | **Today's Date:**

Who can we thank for referring you? | **Sex:** *Male* *Female*

Permanent Address:
City, State, Zip: | **Height:**

Winter Address:
City, State, Zip: | **Weight:**

Which way(s) do you prefer contact? *Home Phone* *Work Phone* *Cell Phone* *Email* | **Date of Birth:**

Home Phone: | **E-Mail:**

Cell Phone: | **Social Security Number:**

Emergency Contact: | **Relationship:** | **Phone:**

Marital Status: | **Number of Children:**

Race: *American Indian* *Alaskan Native* *Asian* *Black or African American* *Native Hawaiian* *White* *Other*

Ethnicity: *Hispanic or Latino* *Not Hispanic or Latino* *Decline to Specify*

Occupation: | **May we contact you at work?** *Yes* *No*

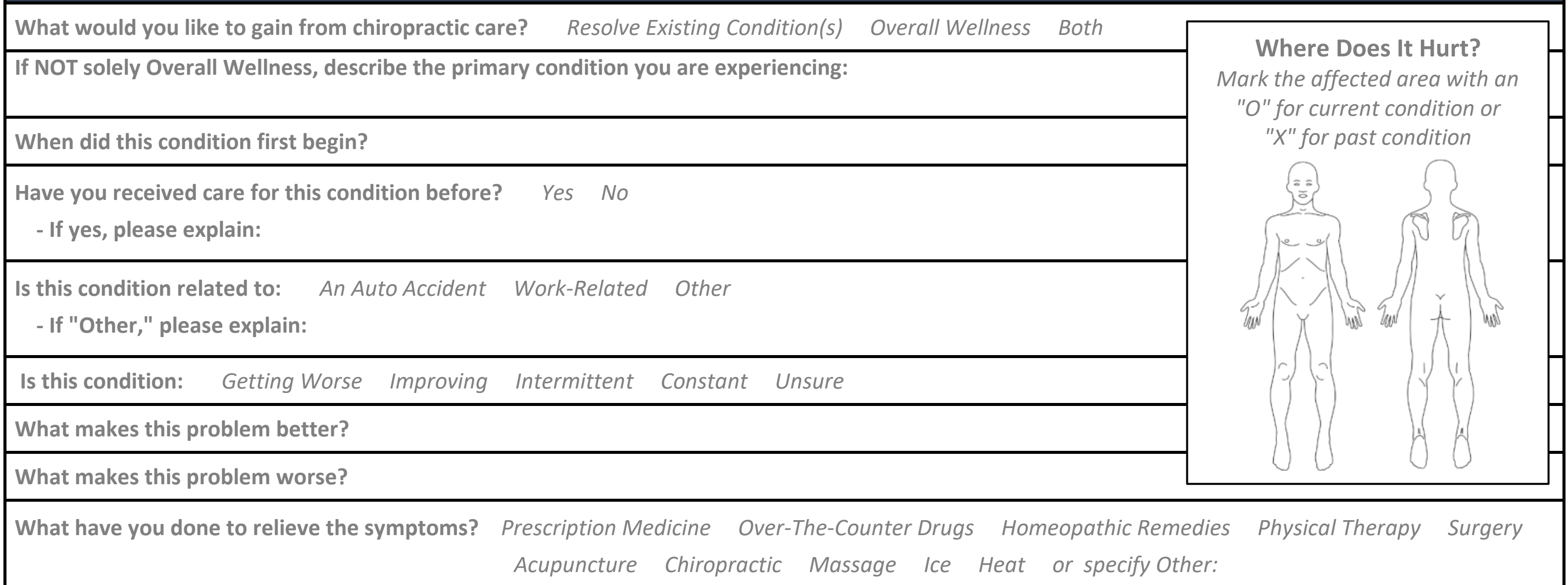
Have you consultated a Doctor of Chiropractic before? *Yes* *No*
- If yes, how long ago? And who was the chiropractor?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? *Yes* *No*
- If yes, please name them and their specialty:

Please note any significant family medical history:



WHAT BROUGHT YOU TO OUR OFFICE TODAY?

What would you like to gain from chiropractic care? *Resolve Existing Condition(s)* *Overall Wellness* *Both*

If NOT solely Overall Wellness, describe the primary condition you are experiencing:

When did this condition first begin?

Have you received care for this condition before? *Yes* *No*
- If yes, please explain:

Is this condition related to: *An Auto Accident* *Work-Related* *Other*
- If "Other," please explain:

Is this condition: *Getting Worse* *Improving* *Intermittent* *Constant* *Unsure*

What makes this problem better?

What makes this problem worse?

Where Does It Hurt?
Mark the affected area with an "O" for current condition or "X" for past condition

What have you done to relieve the symptoms? *Prescription Medicine* *Over-The-Counter Drugs* *Homeopathic Remedies* *Physical Therapy* *Surgery* *Acupuncture* *Chiropractic* *Massage* *Ice* *Heat* *or specify Other:*

Doctor's Initials:

Patient Name: Patient Date of Birth:

ADDITIONAL CARE, CONDITION or COMPLAINT (if needed)

Is this secondary condition a: *Recent Injury* *Worsening Long Term Problem*

Describe the secondary condition you are experiencing:

When did this condition first begin?

Have you received care for this condition before? *Yes* *No*

- If yes, please explain:

Is this condition related to: *An Auto Accident* *Work-Related* *Other*

- If "Other," please explain:

Is this condition: *Getting Worse* *Improving* *Intermittent* *Constant* *Unsure*

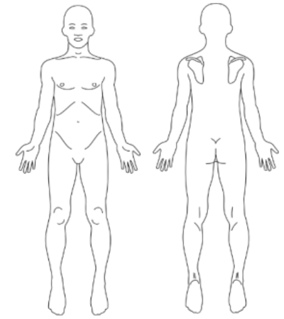
What makes this problem better?

What makes this problem worse?

What have you done to relieve the symptoms? *Prescription Medicine* *Over-The-Counter Drugs* *Homeopathic Remedies* *Physical Therapy* *Surgery* *Acupuncture* *Chiropractic* *Massage* *Ice* *Heat* *or specify Other:*

Where Does It Hurt?

Mark the affected area with an "O" for current condition or "X" for past condition



ADDITIONAL CARE, CONDITION or COMPLAINT (if needed)

Is this tertiary condition a: *Recent Injury* *Worsening Long Term Problem*

Describe the tertiary condition you are experiencing:

When did this condition first begin?

Have you received care for this condition before? *Yes* *No*

- If yes, please explain:

Is this condition related to: *An Auto Accident* *Work-Related* *Other*

- If "Other," please explain:

Is this condition: *Getting Worse* *Improving* *Intermittent* *Constant* *Unsure*

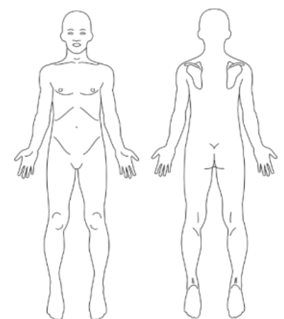
What makes this problem better?

What makes this problem worse?

What have you done to relieve the symptoms? *Prescription Medicine* *Over-The-Counter Drugs* *Homeopathic Remedies* *Physical Therapy* *Surgery* *Acupuncture* *Chiropractic* *Massage* *Ice* *Heat* *or specify Other:*

Where Does It Hurt?

Mark the affected area with an "O" for current condition or "X" for past condition



CONDITION INTERFERENCE

Does this interfere with your work or career?	*Yes*	*No*	**If yes, how?**
Does this interfere with your recreational activities?	*Yes*	*No*	**If yes, how?**
Does this interfere with your household responsibilities?	*Yes*	*No*	**If yes, how?**
Does this interfere with your personal relationships?	*Yes*	*No*	**If yes, how?**

ACTIVITY INTERFERENCE LEVEL (please rate the amount of interferece for each activity below)

Sitting	*None*	*Mild*	*Moderate*	*Severe*	**Grocery Shopping**	*None*	*Mild*	*Moderate*	*Severe*
Rising out of Chair	*None*	*Mild*	*Moderate*	*Severe*	**Household Chores**	*None*	*Mild*	*Moderate*	*Severe*
Standing	*None*	*Mild*	*Moderate*	*Severe*	**Lifting Objects**	*None*	*Mild*	*Moderate*	*Severe*
Walking	*None*	*Mild*	*Moderate*	*Severe*	**Reaching Overhead**	*None*	*Mild*	*Moderate*	*Severe*
Lying Down	*None*	*Mild*	*Moderate*	*Severe*	**Showering or Bathing**	*None*	*Mild*	*Moderate*	*Severe*
Bending Over	*None*	*Mild*	*Moderate*	*Severe*	**Dressing Myself**	*None*	*Mild*	*Moderate*	*Severe*
Climbing Stairs	*None*	*Mild*	*Moderate*	*Severe*	**Exercizing**	*None*	*Mild*	*Moderate*	*Severe*
Using a Computer	*None*	*Mild*	*Moderate*	*Severe*	**Getting to Sleep**	*None*	*Mild*	*Moderate*	*Severe*
Getting in/Out of Car	*None*	*Mild*	*Moderate*	*Severe*	**Staying Asleep**	*None*	*Mild*	*Moderate*	*Severe*
Looking Over Shoulder	*None*	*Mild*	*Moderate*	*Severe*	**Concentrating**	*None*	*Mild*	*Moderate*	*Severe*
Caring for Family	*None*	*Mild*	*Moderate*	*Severe*	**Yard Work**	*None*	*Mild*	*Moderate*	*Severe*
Driving a Car	*None*	*Mild*	*Moderate*	*Severe*					

Doctor's Initials:

Patient Name: Patient Date of Birth:

YOUR VISION FOR YOUR HEALTH

What are your top three health goals?

1

2

3

What's the most significant thing you want to do to improve your health?

On a scale of 1 - 10, how committed are you to reaching & maintaining your health goals? *Least 1 2 3 4 5 6 7 8 9 10 Most*

Is there other information about your current condition(s) that Dr. Kevin should know? *Yes No*

- If yes, please explain:

PERSONAL HEALTH HISTORY

Please help us understand your personal health history, by completing section fully.

TRAUMAS - Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? *Yes No* *None Mild Moderate Severe*

- If yes, please describe:

Any notable childhood injuries? *Yes No*

Any youth or college sports injuries? *Yes No*

Do you commute to work? *Yes No*

If yes, how many minutes each day?

What is your exercise frequency? *None 1-2x Per Week 3-6x Per Week Daily*

- What types of exercise?

Normal sleep position? *Back Side Stomach*

Sleep Hours Per Night?

When you wake: Refreshed/Ready Stiff/Tired

List any problems with flexibility *(ex. Putting on shoes/socks, etc)* **:**

How many hours a day do you typically spend sitting at a desk, on a computer, tablet or phone?

Have you had a Fractured or Broken Bone? *Yes No*
Have you had a Spine or Nerve Disorder? *Yes No*
Have you ever been Knocked Unconscious? *Yes No*
Ever used a Crutch or Other Support? *Yes No*

Ever used a Neck or Back Brace? *Yes No*
Had any Notable Childhood Injuries? *Yes No*
Had any Youth/College Sports Injuries? *Yes No*

TOXINS - Chemical & Environmental Exposure (please rate your consumption of each)

	None		Moderate		High
Alcohol	1	2	3	4	5
Water	1	2	3	4	5
Sugar & Sweets	1	2	3	4	5
Dairy	1	2	3	4	5
Coffee	1	2	3	4	5
Gluten	1	2	3	4	5

	None		Moderate		High
Processed Foods	1	2	3	4	5
Artificial Sweeteners	1	2	3	4	5
Sugary Drinks	1	2	3	4	5
Tobacco	1	2	3	4	5
Mercury Fillings	1	2	3	4	5
Recreational Drugs	1	2	3	4	5

Smoking Status: (age 13 & over): *Never Former Current-Every Day Current-Some Day Heavy Light*

Have you had vaccinations? *Yes No*

Please list any drugs/medications, vitamins, herbs, minerals or other supplements that you are currently taking and why:

EMOTIONS - Thoughts, Stresses & Challenges (please rate your level of each)

	None		Moderate		High
Home	1	2	3	4	5
Work	1	2	3	4	5
Life	1	2	3	4	5
Prayer	1	2	3	4	5

	None		Moderate		High
Money	1	2	3	4	5
Health	1	2	3	4	5
Family	1	2	3	4	5
Meditation	1	2	3	4	5

Doctor's Initials:

Patient Name: Patient Date of Birth:

PERSONAL HEALTH HISTORY - Continued

ILLNESSES (please circle the illnesses you've HAD in the past or HAVE now)

Had	Have	**AIDS**	Had	Have	**Gout**	Had	Have	**Scarlet Fever**
Had	Have	**Alcoholism**	Had	Have	**Heart Disease**	Had	Have	**STD**
Had	Have	**Allergies**	Had	Have	**Hepatitis**	Had	Have	**Stroke**
Had	Have	**Arteriosclerosis**	Had	Have	**HIV Positive**	Had	Have	**Tuberculosis**
Had	Have	**Cancer**	Had	Have	**Malaria**	Had	Have	**Typhoid Fever**
Had	Have	**Chicken Pox**	Had	Have	**Measles**	Had	Have	**Ulcer**
Had	Have	**Diabetes**	Had	Have	**Multiple Sclerosis**	Had	Have	**Other:**
Had	Have	**Epilepsy**	Had	Have	**Mumps**			
Had	Have	**Glaucoma**	Had	Have	**Polio**			
Had	Have	**Goiter**	Had	Have	**Rheumatic Fever**			

OPERATIONS - *Surgical Interventions that may or may not have included hospitalization.*

Yes	No	**Appendix Removal**	Yes	No	**Elective Surgery**	Yes	No	**Spine***
Yes	No	**Bypass Surgery**	Yes	No	**Eye Surgery**	Yes	No	**Tonsillectomy**
Yes	No	**Cancer**	Yes	No	**Hysterectomy**	Yes	No	**Vasectomy**
Yes	No	**Cosmetic Surgery**	Yes	No	**Pacemaker**	Yes	No	**Other***

***If yes to "Spine" or "Other," please explain:**

ALLERGIES

Are you allergic to any medications or foods? *Yes* *No*

- If yes, please list:

TREATMENTS (please circle the treatments you've received in the PAST or are receiving CURRENTLY)

Past	Currently	**Acupunture**	Past	Currently	**Chiropractic Care**	Past	Currently	**Inhaler**
Past	Currently	**Antibiotics**	Past	Currently	**Dialysis**	Past	Currently	**Massage Therapy**
Past	Currently	**Birth Control Pills**	Past	Currently	**Herbs**	Past	Currently	**Physical Therapy**
Past	Currently	**Blood Transfusions**	Past	Currently	**Homeopathy**	Past	Currently	**Medications**
Past	Currently	**Chemotherapy**	Past	Currently	**Hormone Replacement**			

FAMILY HEALTH HISTORY

Because some health issues are hereditary, please give us some insight into the health of your immediate family.

Relative	*Age*	*State of Health*	*Illnesses*	*Age at Death*	*Cause of Death*
Mother		Good Bad			
Father		Good Bad			
Sibling		Good Bad			
Sibling		Good Bad			

ACKNOWLEDGEMENTS, EXPECTATIONS & COMMUNICATION

We're commited to clear expectations & good communication to help you get the best results in the shortest amount of time. Initial your agreement below.

Initials: **I want Dr. Kevin and/or the team members at Chiropractic, Plain & Simple, PLC to deliver the care that, in Dr. Kevin's professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. I am also aware that Chiropractic does not proclaim to cure any named disease or entity.**

Initials: **I grant permission to be contacted to confirm/reschedule an appointment, to be sent occasional cards, letters, emails or health information as an extension of my care in this office.**

Initials: **To the best of my ability and knowledge, the information I have provided is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Initials: **I understand and agree that I am personally responsible for payments due as it relates to the services I receive in this office.**

Patient Name (Print): ____________________ **Today's Date:** __________

Patient (or Parent/Guardian) Signature: ____________________

Doctor's Initials: