KCW
klein chiropractic & wellness

ABOUT YOU

Name

Address

City/State/Zip

Primary Phone

Email

DOB / / Age

Number of Children

Employer Name

Address

City/State/Zip

Work Phone

Position

Spouse Name

Spouse Employer

Cell#

Emergency Contact

Phone

Do you smoke or chew tobacco? Y N

Do you drink alcohol? Y N

_____ Drinks/week

Do you drink coffee, tea, or soda? Y N

_____ Total per week

Do you drink water? Y N

_____ Glasses/day

Do you exercise regularly? Y N

Do you wear: Heel lifts Orthotics Arch supports

CHIROPRACTIC EXPERIENCE

Have you been adjusted by a chiropractor before? Y N

If Yes, what was the reason for the visits?

Date of last visit _____

Who referred you to our office?

TODAY'S VISIT

Describe the reason for this visit

Is the purpose of this visit related to:

Sports Auto Fall Home Injury Work Injury Other

Please Explain _____

When did this condition begin? _____

Has this condition:

Gotten worse Stayed Consistent Comes & goes

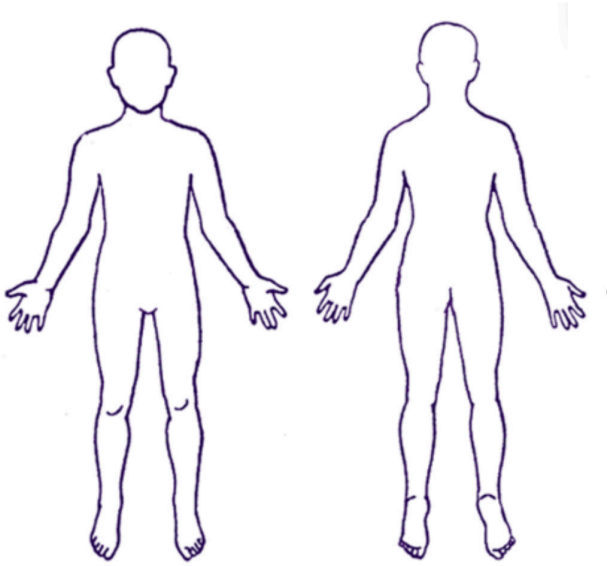
Does this condition interfere with:

Sleep Daily Routine Other Activities

Has this condition occurred before? Y N

Dr's Name _____

Type of Treatment _____



Type of Pain: Dull Sharp Stabbing Numb
Tingling Achy

Does the pain radiate? Y N

If so, where to? _____

_____

MEDICATIONS YOU TAKE

Cholesterol Blood Pressure Medication

Tranquilizers Blood Thinners Muscle Relaxers

Pain Killers Insulin Stimulants

Other _____

Vitamins/Supplements _____

_____

FOR WOMEN ONLY

Are you pregnant? Y N

If yes, when is your due date? _____

Are you breastfeeding? Y N

Do you have irregular/painful menstrual cycles? Y N

Do you have breast implants? Y N

HEALTH CONDITIONS

Please circle each of the diseases or conditions that you now have or have had in the past:

Artificial bones/joints	Shingles	Cancer	
Heart Surgery/Pacemaker	Tuberculosis Thyroid issues	Congenital heart defect	Rheumatic Fever
Heart Disease	Anemia	Low blood pressure	Arthritis
Hepititis	Breathing Problems	Loss of Sleep	Diabetes
Hyperactivity	Neck Pain	Headaches	Low Back Pain
Stroke	Fractures		

Surgeries/Hospitalization _____

_____

Office Policy Records are the property of our office. Copies are only given with written permission and appropriate copying fees. If you do not understand the procedures in your course of care, please ask. If you don't ask, we assume that you understand and consent to treatment. Insurance policies are an arrangement between you and your Insurance company, NOT between the insurance company and this office. You are responsible for any balance at this office.

We accept MC/VISA/DISCOVER/AM EXPRESS

Please INITIAL the following:

I have been provided and read and agree to the privacy, marketing, and fundraising policies of this office. _____

I agree to have my name put on a referral board if I refer a family member/friend._____

I authorize the release of information necessary to process my health insurance claims_____

I allow my picture (or child's picture) to be used for marketing purposes including being posted on social media, emails, blogs, newsletters. This authorization will continue indefinitely unless I revoke permission in writing. _____

Patient Signature _____ Relationship to Patient _____

Date _____