KINESIOLOGY
CHIROPRACTIC PLUS

DATE: _____

NAME: _____ PREFERRED TO BE CALLED: _____

DATE OF BIRTH_____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ EMAIL: _____

PARENT/GUARDIAN FOR MINOR: _____

EMPLOYER: _____

INSURANCE CARRIER: _____ POLICY ID: _____

MEDICARE: Y N REFERRED BY: _____

MARRIED: Y N

ISSUE TO BE ADDRESSED:

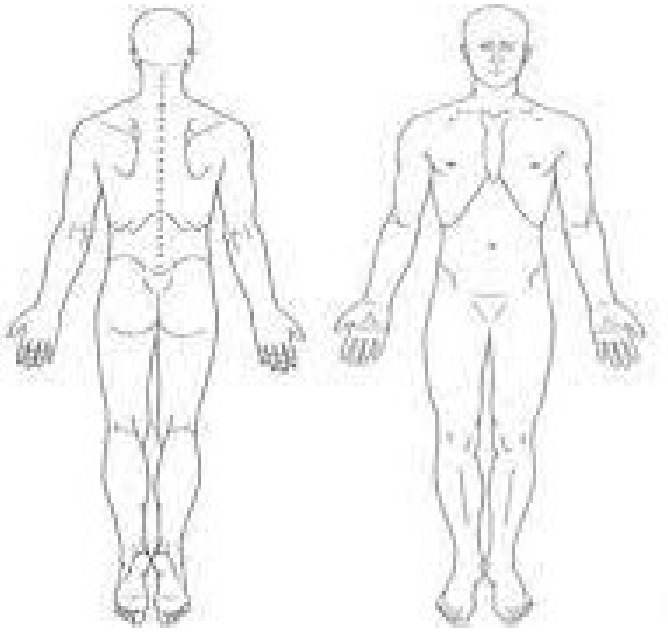
1._____

DATE OF OCCURRENCE: _____

2._____

DATE OF OCCURRENCE: _____

MARK THE LOCATION OF YOUR PAIN BELOW:



DO THE FOLLOWING AFFECT YOU

	BETTER	WORSE
SITTING	_____	_____
STANDING	_____	_____
WALKING	_____	_____
LYING DOWN	_____	_____
DURING THE NIGHT	_____	_____
MORNINGS	_____	_____
END OF DAY	_____	_____
HIGHLY ACTIVE	_____	_____
RESTING	_____	_____

Are you currently taking any medications, vitamins, minerals, etc.? How long? What for?

_____

_____

What previous methods have you tried to alleviate your discomfort? And did they help?

_____

Have you seen another Physician for this problem? Yes/No Name: _____

Was this beneficial? Yes/No

List and major traumas (car accident/falls/injuries) with dated: _____

_____

Any major diseases? (Please include dates): _____

_____

List any surgeries or dental work. Please include dates: _____

_____

_____

Any other symptoms or problems you are currently experiencing? _____

_____

Do exercise regularly? Yes/No What does it consist of: _____

_____

Have you in the last year experienced?		For Women	
Death of a loved one	____	Menstrual issues	____
Divorce or Separation	____	Extreme flow	____
Serious Injury or illness of a family member	____	Cramping	____
Marriage	____	Pre-menstrual depression	____
Loss of a job/job stress	____	Post-menstrual depression	____
Employment change	____	Breast discomfort/pain	____
Retirement	____	Hot flashes	____
Pregnancy or birth of a child	____	Menopause	____
Sexual problems	____	Are you currently pregnant	____
Change in personal habits	____	On average, how many days do you menstruate?	
Change in living conditions	____		____
Extreme stress	____	Date of last menstrual period	____

How many per day:

Cups of coffee ___ Tea ___ Glasses of Milk ____ Bottles/cans of Juice ___ Soda ___

Glasses of water ____ (city, well, filtered)

Hours of Sleep _____ Do you feel rested? Yes/No

Food allergies: Yes/No What foods: _____

Drug allergies: Yes/No Which ones: _____

Environmental allergies: Yes/No Which ones: _____

When it comes to remembering things in your life, are you more

Visual (Seeing) _____ Auditory (Hearing) _____ Kinesthetic (Feeling) _____

On a scale from 0 – 10 (0 = none, 10 = High), rate your Pain levels:

Daily average _____ Currently ____

Patient Payment Policy

1. Patients are expected to take care of their fees as services are rendered.
2. Patients who carry health insurance that we do not participate with are expected to cover fees upfront. A detailed receipt can be produced for you to submit to your insurance.
3. Patients with health insurance we do participate with are expected to cover their Copayment/Coinsurance/Deductible at time of service.
4. For non-insurance patients, we do offer package discounts. Ask the front desk for more information.

I have read the above and agree to be financially responsible for all charges acquired with my visits to Chiropractic Plus. All deductibles, copayments, coinsurances or non-insurance payments will be made at the time of service.

_____ _____

Patient Signature **Date**

Your Thoughts are critical to our success in helping you. Your nervous system is the master system and controller of your body. Health and wellness are therefore mediated through your nervous system. In our office we have a unique and modern approach to supporting and expanding your health by improving how your nervous system performs.

Lifestyle stress adversely affects your nervous system and general health. Many times, when people think they have a "back problem", what they are really having is a health problem. This is a result from the way they are living.

If we could make recommendations that would not only address your main concerns, but could also help improve your overall health, would you like to hear them? **Yes/No**