New Patient Form

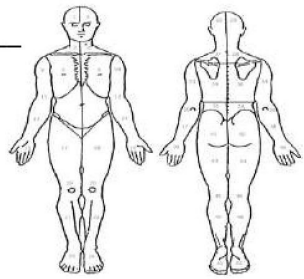
Klinedinst Chiropractic
106 Martin Ave – Canton, IL 61520
309-647-8030

Patient Name _____ Date of Birth _____ Today's Date _____

Patient Address _____City and State _____ ZIP_____

Cell Phone # ( )_____ Cell Phone Carrier _____ Sex_____

E-mail _____ Marital Status _____



Primary Ins. Name _____ ID# _____ DOB _____

Secondary Ins Name _____ID#_____

Social Security Number _____ Occupation _____

Employer/School _____ Employer/School # (____)- _____-_____

Spouse's Name _____ Spouse Employer _____

How did you hear about us?_____ Emergency Name and # _____

Place a mark on "Yes" or "No" to indicate if you have had any of the

	Yes	No		Yes	No		Yes	No		Yes	No
Aids/HIV	☐	☐	Convulsions	☐	☐	High Blood Pressure	☐	☐	Radiation Treatments	☐	☐
AFIB	☐	☐	Cortisone Meds	☐	☐	High Cholesterol	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Diabetes	☐	☐	Hives/Rash	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Drug Addiction	☐	☐	Kidney Problems	☐	☐	Shingles	☐	☐
Arthritis	☐	☐	Easily Winded	☐	☐	Leukemia	☐	☐	Sinus Trouble	☐	☐
Artificial Heart Valve	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Spina Bifida	☐	☐
Artificial Joint	☐	☐	Epilepsy	☐	☐	Low Blood Pressure	☐	☐	Stomach Disease	☐	☐
Asthma	☐	☐	Excessive Thirst	☐	☐	Lung Disease	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	Fainting spells	☐	☐	Migraine	☐	☐	Thyroid Disease	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Bruise Easily	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Heart Murmur	☐	☐	Pain in Jaw	☐	☐	Tumors/Growths	☐	☐
Chemotherapy	☐	☐	Heart Pacemaker	☐	☐	Joints	☐	☐	Ulcers	☐	☐
Chest Pains	☐	☐	Heart Trouble/Disease	☐	☐	Parathyroid Disease	☐	☐	Vertigo	☐	☐
Congenital Heart Disorder	☐	☐	Hepatitis A,B,C	☐	☐	Psychiatric Care	☐	☐	Whiplash	☐	☐

	Exercise		Work Activity		Habits	
☐	None	☐	Sitting	☐	Smoking	Packs/Day _____
☐	Moderate	☐	Standing	☐	Alcohol	Drinks/Week _____
☐	Daily	☐	Light Labor	☐	Coffee/Caffeine Drinks	Cups/Day _____
☐	Heavy	☐	Heavy Labor	☐	High Stress Level	Reason _____

Family History of any illnesses : _____

Are you Pregnant? ☐ Yes ☐ No

Name _____ Patient Update Date: _____

What is your Chief Complaint? _____Secondary Complaint_____

Is your pain Constant or does it Come and Go?

When did your symptoms / Complaint appear? _____

How did your condition Happen? _____

_____

_____

Has your condition: Gotten Worse Gotten Better Stayed The Same

What makes the pain / symptoms worse? Walking Going to/Sitting Going to/Standing Desk Work Lying Down Twisting/Turn Bending Lifting Driving Sports Ice/Heat Sleeping

Other _____

What makes the pain / symptoms better? Nothing Walking Sitting Standing Rest Cold / Heat over the counter Meds Prescription Meds Stretching Massage Bio Freeze Lying Down Twisting/Turn Bending Lifting Driving Sports Ice/Heat Sleeping

Other _____

What does the Pain / Symptoms feel like? Burning Cramps Dull/Achy Localized Sharp Stiffness Shooting Stabbing Throbbing Tightness Numbness/Tingling Other_____

Does the Pain travel? YES NO Where? _____

_____

Pain Level 1 (Best) 2 3 4 5 6 7 8 9 10 (Call the ambulance) WITH ACTIVITY WITH REST (Circle)

When do you have most of your pain? Morning Afternoon Evening While Sleeping ALL DAY

Have you ever seen a Chiropractor YES NO When and who? _____

Have you seen anyone else (MD, DO, Surgeon?) for this issue? _____

_____

Any Auto Accidents? YES NO When and brief description _____

_____

Falls or Injuries? YES NO Description _____

_____

Surgeries? YES NO Description _____

_____

Any other health Concerns? _____

_____

_____