

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 \_\_\_\_\_

Patient Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Social Security Number \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse Employer \_\_\_\_\_

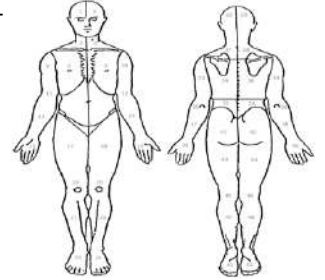
Primary Ins. Name \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Ins Name \_\_\_\_\_ ID# \_\_\_\_\_

E-mail \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_ Employer/School # (\_\_\_\_)-\_\_\_\_-\_\_\_\_

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

AIDS/HIV	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chicken Pox	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatoid Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Alcoholism	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Measles	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatic Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Allergy Shots	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Emphysema	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Migraine Headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Scarlet Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Epilepsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Miscarriage	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anorexia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fractures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mononucleosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Suicide Attempt	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Appendicitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Glaucoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Multiple Sclerosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thyroid Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Goiter	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mumps	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tonsillitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Gonorrhea	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Osteoporosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bleeding Disorders	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Gout	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tumors, Growths	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Breast Lump	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Parkinson's Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Typhoid Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bronchitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hepatitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pinched Nerve	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ulcers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bullimi	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hernia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pneumonia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vaginal Infections	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Herniated Disk	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Polio	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Venereal Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cataracts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Herpes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Prostate Problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Whooping Cough	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Chemical Dependency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High Cholesterol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Prosthesis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other _____				
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Psychiatric Care	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____				

<b>Exercise</b>		<b>Work Activity</b>		<b>Habits</b>	
<input type="checkbox"/>	None	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Standing	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Daily	<input type="checkbox"/>	Light Labor	<input type="checkbox"/>	Coffee/Caffeine Drinks
<input type="checkbox"/>	Heavy	<input type="checkbox"/>	Heavy Labor	<input type="checkbox"/>	High Stress Level
					Packs/Day _____
					Drinks/Week _____
					Cups/Day _____
					Reason _____

Family History of any illnesses : \_\_\_\_\_

Are you Pregnant?  Yes  No