PATIENT INFORMATION (please print)

Last Name_____ First_____ MI____

Nickname_____ Address _____

City _____State _____Zip _____Home Ph: _____

Office Ph: _____ Cell Ph: _____ E-mail: _____

Age ___ Date of Birth _____ Social Security No._____ Sex **M** **F**

Referred by _____ Attorney _____

Occupation_____Employer_____

Address _____ Primary Care Physician_____

Married ___ S ___ W ___ D ___ Children ____ Spouse's Name _____

RESPONSIBLE PARTY

Full Name_____Relationship_____

Address_____ City_____ State_____ Zip_____

Home Ph_____ Business Ph_____ Social Security No._____

Employer_____Address_____

MEDICAL INSURANCE INFORMATION

Health Ins. ____ Worker's Comp. ____ Auto Liability ____ Medical Payments ____ Other ____

Insurance Carrier_____ Id/Policy No._____ Group No._____

Subscriber _____ Date of Birth _____Relationship _____

Secondary Carrier_____ Id/Policy No._____ Group No. _____

Subscriber _____ Date of Birth _____ Relationship _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS

I authorize **Karr Chiropractic Health** to release medical information for insurance purposes concerning my treatment. I assign my rights to benefits to **Karr Chiropractic Health.**

Patient Signature_____ **Date**_____

Patient Name _____ **Date** _____

HEALTH HISTORY INFORMATION (circle yes or no)

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? **Yes** **No** Were results satisfactory? **Yes** **No**

For what problem? _____

Major complaints and symptoms — please be as specific as you can._____

_____

How do you believe your problem (pain) began? _____

_____

When did you first notice this problem/pain? _____

Have you lost any work? **Yes** **No** Day and date you last worked _____

Have you ever had this condition before or a similar condition? **Yes** **No** When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever been treated by a Medical Provider for this ailment? **Yes** **No** Who/where? _____ Provider's Diagnosis _____

Describe the type of treatment _____

Length of time under care_____ Results _____

Have you ever been in **any accidents** i.e. auto, fall down stairs, fall from ladder, etc. (even as a child)? **Yes** **No** If yes, what and when? _____

Are you allergic to anything you are aware of? **Yes** **No** Substance? _____

_____

Are you presently taking any medication, herbs, supplements or over the counter products (aspirin included)? **Yes** **No** If yes, name them _____

_____

Have you ever broken any bones? (Fractures) _____ Any dislocations? _____

What operations have you had? 1) _____Year _____ 2) _____Year _____

3) _____Year _____ 4) _____Year _____

Have you ever had any cosmetic surgery, breast implants, etc.? **Yes** **No**

Body area? 1) _____Year _____ 2) _____Year _____

Have you had any surgery to replace hip, knee, etc.? **Yes** **No**

Body area? 1) _____Year _____ 2) _____Year _____

If you have had any of the following procedures, please give **date**, treating **doctor**, and treating **facility** (if exact date is unknown, give approximate):

Blood tests _____ Urinalysis _____

X-Ray examination _____ Ultrasound _____

MRI _____ CT Scan _____

Radiation Treatment _____ Other special treatment _____

Have you been treated for any health condition by a physician in the past year? **Yes** **No**

If yes, what condition? _____

Do you have any health problems not listed above? _____

Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? **Yes** **No**

Do you faint easily? **Yes** **No** Have you been diagnosed with hypertension? **Yes** **No**

Do you take vitamins? **Yes** **No** If yes, please list them _____

_____

Do you exercise regularly? **Yes** **No** What kind of exercise? _____

_____

Have you lost or gained weight in the past year? **Yes** **No** Amount_____

Habits: (please check)

Cigarettes? **Yes** **No** Packs _____per day Coffee? **Yes** **No** Cups _____per day

Alcohol? **Yes** **No** Drinks _____per day/week Tea? **Yes** **No** Cups _____per day

Hobbies? _____

Use this space for any additional information you may wish to discuss. _____

_____

REVIEW OF SYSTEMS

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions **Now** (within the past 12 months) or **P** if you ever had these conditions in the **Past**.

	N or P		N or P		N or P
Headaches	____	Weakness in Legs	____	Stomach Upset	____
Neck Pain	____	Shortness of Breath	____	Constipation	____
Stiff Neck	____	Fatigue	____	Cold Sweats	____
Sleeping Problems	____	Depression	____	Fever	____
Back Pain	____	Lights Bother Eye	____	Sinus Problems	____
Nervousness	____	Loss of Memory	____	Diabetes	____
Tension	____	Ears Ring	____	Hemorrhoids	____
Irritability	____	Face Flushed	____	Leg Cramps	____
Chest Pains	____	Buzzing in Ears	____	Colitis	____
Dizziness	____	Loss of Balance	____	Gall Bladder	____
Shoulder/Neck/Arm Pain	____	Fainting	____	Indigestion	____
Pins & Needles in Arms	____	Loss of Smell	____	Belching	____
Pins & Needles in Legs	____	Loss of Taste	____	Vomiting	____
Numbness in Fingers	____	Diarrhea	____	Shoulder Pain	____
Numbness in Toes	____	Feet Cold	____	Swelling Joints	____
High Blood Pressure	____	Hands Cold	____	Knee Pain	____
Difficulty Urinating	____	Arthritis	____	Hay Fever	____
Allergies	____	Muscle Spasms	____	Menstrual Difficulties	____
Weakness in Arms	____	Frequent Colds	____		

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **Karr Chiropractic Health** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature_____ **Date**_____