

CHIROPRACTIC ASSOCIATES OF KENOSHA
3120 80TH ST KENOSHA, WI 53142

PATIENT INFORMATION

Name: _____

Social Security Number: _____ - _____ - _____ Referred By: _____

Address: _____

Home Phone: _____ Cell _____ Work _____ email _____

Date of Birth: _____ Age: _____ Sex: M F Number of Children: _____

Marital Status (Circle One): M S W D Driver's License No: _____

Employer: _____ Address: _____

Occupation: _____ Supervisor: _____

Parent (if minor) _____ or Spouse's Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Have you ever been a patient of this office? Yes No
Are you or could you be pregnant at this time? Yes No Unsure Not Applicable

How did you hear about our office? _____

Is your injury related to work? NO YES
If YES, date of injury ____/____/____
Did you report the injury to your supervisor? NO YES

Is your injury related to an auto accident? NO YES
If YES, date of accident ____/____/____
Was a police report filed? NO YES

How do you intend on paying for today's visit? _____

CO-PAYS AND CO-INSURANCE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If I suspend or terminate my care and treatment, any fees for professional services rendered to me will immediately be due and payable.

I also understand that if I am accepted as a patient of CHIROPRACTIC ASSOCIATES OF KENOSHA, S.C., I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

Patient Signature

Date

Parent/Guardian Signature Authorizes Care of Minor

Date

NAME: _____ **DATE:** _____

What is the primary reason for your visit today? _____

1. Please describe your complaint: Sharp pain dull pain ache weak throbbing numbness tingling shooting burning

2. Frequency: Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

3. Indicate intensity of your pain at its lowest and highest level: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most pain)

4. Are your symptoms Decreasing Not changing Getting worse

5. Symptoms are worse in the Morning Afternoon Night Same all day

6. Does the problem/pain radiate or travel to any other areas in the body? _____

7. Describe how your problem began: _____

8. Have you been treated for this condition before? Yes No
If yes, by whom? Another Chiropractor Medical doctor Physical therapist Massage therapist Other _____
Are you currently begin seen? Yes No If so, how often and what treatments? _____

9. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/exercise Inactivity

10. What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity

11. How would you rate your general stress level? Little/none Minimal Moderate Great stress

12. General Physical Activity: No regular exercise Light exercise Moderate exercise Strenuous exercise

13. Are you complaints affecting your ability to be active? Circle appropriate selections below:
No effect Able to perform light duty work and household tasks Need limited assistance to perform tasks
Need assistance often Have a significant inability to function without assistance I am totally disabled (impaired)

14. Physical activity at work: Sitting 50% or more of work day Light manual labor Manual labor Heavy manual labor

15. Has your work status changed because of this complaint? Yes No

16. What is your current work status? Full time/no restrictions Full time with restrictions Part time/no restrictions
Part time with restrictions Off work due to restrictions Retired
Full time homemaker Full time student

17. Do you have a permanent disability? Location _____ Rating percentage _____% Date received _____

PAST HEALTH HISTORY

Mark all that apply:

Symptom	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Hip or leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>

PRESENT HEALTH STATUS

Height: _____ Ft. _____ In

Weight: _____ lbs.

Tobacco Use: _____ Never _____ Infrequent 1/2 pack/wk _____ Moderate 1 pack/wk _____ Heavy 2+ packs/wk

Alcohol Use: _____ Never _____ Infrequent 1-2/wk _____ Moderate 3-5/wk _____ Heavy 6+/wk

Caffeine Use: _____ Never _____ Infrequent 1-2/wk _____ Moderate 3-5/wk _____ Heavy 6+/wk

Drug/Medications:

Surgeries/Hospitalizations:

Previous Illnesses:

Previous Traumas:

Please let us know of any family history of the following illnesses. Circle M for mother's side of family, F for father's side of family.

Heart disease	M	F	N/A	Back Problems	M	F	N/A
High Blood Pressure	M	F	N/A	Migraines	M	F	N/A
Stroke	M	F	N/A	Epilepsy/Seizures	M	F	N/A
Arthritis	M	F	N/A	Allergies/Asthma	M	F	N/A
Diabetes	M	F	N/A	Cancer	M	F	N/A

Other: _____

Patient/Guardian Signature _____

Date _____