Kelly Chiropractic Patient Information & Health History

Date ____/_____/_____ Patient #_____

Patient Information

Name: _____

Date of Birth _____/_____/_____

Address: _____

City: _____ State: ____ Zip: _____

Sex: ◯ M ◯ F

Social Security #: _____

Occupation: _____

Employer/School: _____

Marital Status: ◯ Single ◯ Married
◯ Widowed ◯ Divorced

Spouse's Name: _____

# of Children: _____

Whom may we thank for referring you?

_____

Contact Information

Email: _____

Home Phone # (_____) _____ - _____

Cell Phone # (_____) _____-_____

Work Phone # (_____) _____-_____

Preferred Method of Contact: (Please circle)

Home Phone Cell Phone Work Phone Email

Is it okay to text you? ◯ Yes ◯ No

In Case of Emergency, Contact

Name: _____

Relationship: _____

Phone # (_____) _____-_____

Insurance Information

Who is responsible for this account?

_____

Relationship to Patient: _____

Primary Insurance:

Insurance Co: _____

Contract/ID #: _____

Group #:_____

Subscriber's Name: _____

Date of Birth: _____/_____/_____

Secondary Insurance: ◯ None

Insurance Co: _____

Contract/ID #: _____

Group #:_____

Subscriber's Name: _____

Date of Birth: _____/_____/_____

Accident Information

Is condition due to an accident? Yes No

Date of accident? _____/_____/_____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Ins. Employer Workers Comp Other

Have you been seen by anyone else in relationship to this condition? Yes No

Who/Where?_____

Attorney Name: _____
(If applicable)

Kelly Chiropractic Patient Health History

Patient Condition

What brought you here today? _____

When did your symptoms appear? _____

Pain Scale (Circle the # that best describes your pain level)

0 1 2 3 4 5 6 7 8 9 10
None Little Moderate Worst

Is the pain?* ◯ Constant ◯ Intermittent ◯ Radiating

◯ Getting Worse ◯ Getting Better

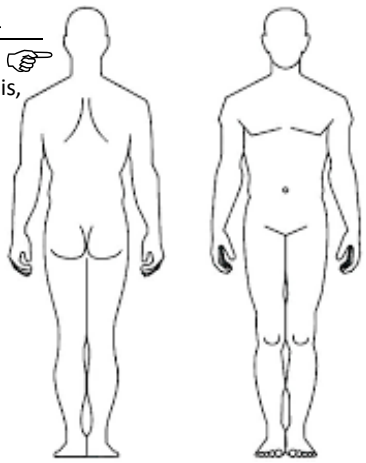
Difficulty with extended:* ◯ Standing ◯ Sitting ◯ Riding

◯ Bending ◯ Twisting ◯ Household Duties ◯ Lifting

*Check all that apply

Indicate on the drawing where you are experience pain & what type of pain it is, using the letters below to describe it

A – Ache N - Numbness
B – Burning ST - Stiffness
P – Pins and Needles
S – Sharp Stabbing/Shooting
O – Other



Have you had this condition in the past? ◯ Yes ◯ No

Have you seen anyone else regarding this condition? ◯ Yes ◯ No

If yes, Who & Where? _____

Please indicate current and past issues with discomfort in the following areas (circle right and/or left, if applicable)

	Pain			Stiffness			Numbness		
	Current	Past	Never	Current	Past	Never	Current	Past	Never
Head	◯	◯	◯	◯	◯	◯	◯	◯	◯
Neck	◯	◯	◯	◯	◯	◯	◯	◯	◯
Shoulder (RT / LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Hand (RT/LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Upper Back	◯	◯	◯	◯	◯	◯	◯	◯	◯
Mid Back	◯	◯	◯	◯	◯	◯	◯	◯	◯
Low Back	◯	◯	◯	◯	◯	◯	◯	◯	◯
Buttocks (RT / LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Hip (RT / LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Leg (RT / LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Knee (RT / LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯
Foot (RT/LT)	◯	◯	◯	◯	◯	◯	◯	◯	◯

Family & Patient History

Please indicate any family or person history

	Family History		Personal History		
	Yes	No	Current	Past	Never
Arthritis	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯
Back Problems	◯	◯	◯	◯	◯
Scoliosis	◯	◯	◯	◯	◯
Allergies	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯
High or Low Blood Pressure	◯	◯	◯	◯	◯
Stroke	◯	◯	◯	◯	◯

Patient Signature _____ Date ____/_____/_____

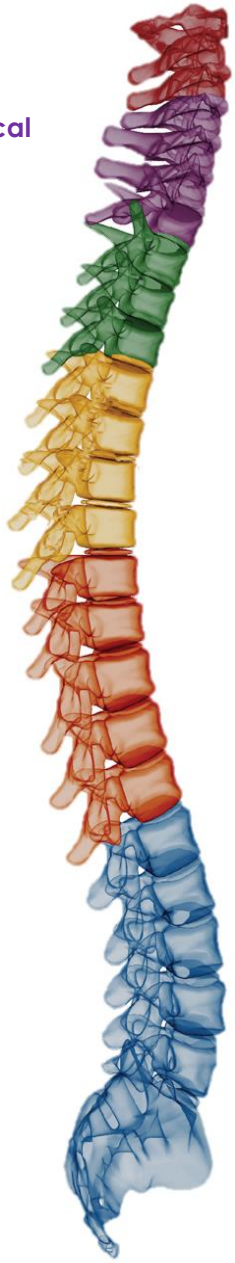
Date of Birth _____/_____/_____

Kelly Chiropractic Patient Health History & Review of Systems

Patient Name _____ Date of Birth ____/_____/_____

Please check the corresponding box for each symptom or condition you have experienced – past and present

Regions



Cervical

Upper Thoracic

Mid Thoracic

Lower Thoracic

Lumbar, Sacrum & Pelvis

Symptoms

Past	Present		Past	Present	
☐	☐	Colic & Excessive Crying	☐	☐	Focus & Memory Issues
☐	☐	Sinus Infections/Problems	☐	☐	Balance & Coordination
☐	☐	Headaches / Migraines	☐	☐	Speech Issues
☐	☐	Vertigo	☐	☐	TMJ / Jaw Pain
☐	☐	Sore Throat & Strep	☐	☐	Tremors
☐	☐	Swollen Tonsils & Adenoids	☐	☐	Poor Metabolism & Weight Control
☐	☐	Hearing Loss / Issues	☐	☐	Dyslexia
☐	☐	Eye Sensitivity to Light	☐	☐	Ear Infections
☐	☐	Epilepsy / Seizures	☐	☐	Mistake Right from Left
☐	☐	Sensory & Spectrum	☐	☐	Head Seems to Heavy
☐	☐	ADD/ADHD	☐	☐	Head & Shoulders Feel Tired
☐	☐	Reflux/GERD	☐	☐	Bronchitis & Pneumonia
☐	☐	Chronic Colds & Cough	☐	☐	Functional Heart Conditions
☐	☐	Gallbladder Pain/Issues	☐	☐	Indigestion & Heartburn
☐	☐	Jaundice	☐	☐	Stomach Pains & Ulcers
☐	☐	Fever	☐	☐	Liver Trouble
☐	☐	Hepatitis			
☐	☐	Behavior Issues	☐	☐	Hyperactivity
☐	☐	Kidney Problems	☐	☐	Losses Temper Easily
☐	☐	Excessive Gas	☐	☐	Belching / Bloating after Meals
☐	☐	Chrohn's, Colitis and/or IBS	☐	☐	Sciatica & Radiating Pain
☐	☐	Colon Issues	☐	☐	Hamstring Tightness
☐	☐	Bed Wetting	☐	☐	Varicose Veins
☐	☐	Gluten / Casein Intolerance	☐	☐	Leg Weakness and/or Cramps
☐	☐	Infertility	☐	☐	Poor Circulation and/or Cold Feet
☐	☐	Impotency	☐	☐	Cramps and/or Menstrual Issues
☐	☐	Hemorrhoids	☐	☐	Cysts and/or Endometriosis

Last Dental Appt. _____/_____/_____ Last Eye Exam _____/_____/_____

Last Physical Exam _____/_____/_____ Do you wear heel lifts? ◯ Yes ◯ No Arch supports? ◯ Yes ◯ No

Females Only

Date of Last Menstrual Cycle _____/_____/_____ Are you pregnant? ◯ Yes ◯ No

Do you experience breast lumps, soreness and/or discharge? ◯ Currently ◯ In the Past

Kelly Chiropractic Patient Health History & Review of Systems

Illness

Please list all current and past Illnesses

_____

_____

Hospitalizations & Surgeries

Please list all past Hospitalizations & Surgeries with Dates

_____

_____

_____

Medications, Vitamins & Supplements

Please list all current Medications, Vitamins & Supplements *

_____

_____

_____

* If you have a list please indicate that here and present it to the front desk to be copied. ◯ See List

Systems Review

Please circle all that apply

Do you have any ill feelings?
◯ No symptoms
DECREASED ACTIVITY LEVEL
FEVER
CHILLS
FATIGUE
NIGHT SWEATS
LOSS OF APPETITE
WEIGHT LOSS
WEIGHT GAIN
LOSS OF ENERGY
UNCONTROLLED SWEATING

Do you have any symptoms of heart trouble?
◯ No heart problems
CHEST PAIN
PALPATATIONS
FAINTING
SHORTNESS OF BREATH
ANKLE SWELLING

Do you have any skin problems?
◯ No skin problems
RASH
ITCHING
DRYNESS
LESIONS
OPEN WOUND/INFECTION
HAIR/NAIL CHANGES

Do you have any mental health problems?
◯ No mental health problems
IRRITABILITY
DEPRESSION
DISTURBED SLEEP
SUCICIDAL THOUGHTS
ANXIETY
NERVOUSNESS

Do you have any breathing problems?
◯ No breathing problems
COUGHING
WHEEZING
SHORTNESS OF BREATH

Do you have any immunity problems?
◯ No immune system problems
ENLARGED LYMPH NODES
HIVES
HAY FEVER
PERSISTANT INFECTION

Do you have any neurological problems?
◯ No neurological problems
SEIZURES
ABNORMAL SENSORY FEELINGS IN EXTREMITY
LOSS OF MEMORY

Do you have any trouble urinating?
◯ No problems with urination
FREQUENT URINATION
URGENCY
TROUBLE STOPPING OR STARTING STREAM
ERECTILE DYSFUNCTION
NOCTURIA
BURNING WITH URINATION
LOSING CONTROL/INCONTINENCE
BOWEL DYSFUNCTION
SEXUAL DYSFUNCTION
HESITANCY

Do you have any stomach problems?
◯ No stomach problems
NAUSEA
VOMITING
DIARRHEA
CONSTIPATION
LOSS OF BOWEL CONTROL

Do you have any bruising or bleeding problems?
◯ No bruising or bleeding problems
HISTORY OF ANEMIA
ABNORMAL BLEEDING
BRUISING
HEAT INTOLERANCE
COLD INTOLERANCE

Do you have trouble with your vision?
◯ No visual problems
BLURRED VISION
DOUBLE VISION
VISION LOSS
EYE PAIN
WEAR GLASSES/CONTACTS

Do you have any muscle or joint problems?
◯ No muscle or joint problems
JOINT PAIN
JOINT WEAKNESS
MUSCLE WEAKNESS

Do you have any endocrine problems?
◯ No endocrine problems
DIABETES
THYROID DISORDER

Patient Signature _____ Date _____/_____/_____

Date of Birth _____/_____/_____

Kelly Chiropractic Patient Social History

Patient Name _____ Date of Birth _____/_____/_____

Education

Highest level of education completed

◯ not completed high school ◯ high school graduate ◯ Master's Degree ◯ medical school grad
◯ GED diploma or Equivalent ◯ an associate's degree ◯ PH.D ◯ completed a doctorate
◯ completed trade school ◯ a bachelor's degree ◯ law school grad program (other than medical)

Diet

Do you eat a well-balanced diet?
◯ Never
◯ Rarely
◯ Occasionally
◯ Usually

Do you eat sweets?
◯ Heavy
◯ Moderate
◯ Light
◯ None

Describe your appetite?
◯ Heavy
◯ Moderate
◯ Light
◯ None

Describe your caffeine intake?
◯ Heavy
◯ Moderate
◯ Light
◯ None

Have you ever been treated for or suffered from an eating disorder? ◯ Currently ◯ In the Past

Exercise

Do you exercise?
◯ Never
◯ Rarely
◯ Occasionally
◯ Usually
◯ Regularly

Types of Exercise (circle all that apply)

running/jogging	baseball	swimming
walking	basketball	tennis
weightlifting	football	Other (Please list below)
yoga/Pilates	golf	_____
group exercises	soccer	_____

Sleep

Describe your sleep? ◯ Heavy ◯ Moderate ◯ Light ◯ None

Substance Use

Do you drink alcohol?
◯ Never ◯ Occasionally ◯ Frequently (more than 3 days per week) ◯ Daily

Do you use tobacco products?
◯ Never ◯ Occasionally ◯ Frequently (more than 3 days per week) ◯ Daily

Have you ever used illegal drugs? ◯ Yes ◯ No
If yes, please list below

_____
_____
_____
_____

Have you ever had a substance abuse problem? ◯ Yes ◯ No
If yes, please list below

_____
_____
_____
_____

Have you had treatment for your substance abuse? ◯ Yes ◯ No

STI/STDs

Have you ever had or been treated for a sexual transmitted infection/disease? ◯ Yes ◯ No

If yes, please list and indicate whether it is current or past: _____ ◯ Current ◯ Past

_____ ◯ Current ◯ Past _____ ◯ Current ◯ Past

Kelly Chiropractic Patient Accident and Fall History

Accident & Fall History

Have you ever been in an auto accident? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

Have you ever had a significant accident or fall? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

Have you ever been knocked unconscious? ◯ Yes ◯ No

If yes, please list indicated when: _____/_____/_____ Did you seek medical attention? ◯ Yes ◯ No

Have you ever fractured or broken a bone? ◯ Yes ◯ No

If yes, please list indicated what bone? _____ when? _____/_____/_____

If yes, please list indicated what bone? _____ when? _____/_____/_____

If yes, please list indicated what bone? _____ when? _____/_____/_____

Additional Information

Is there any additional information that you would like the Kelly Chiropractic team to know that would assist us in providing the best chiropractic care?

_____

_____

_____

_____

_____

Patient Signature _____ Date _____/_____/_____

Date of Birth _____/_____/_____