

# 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

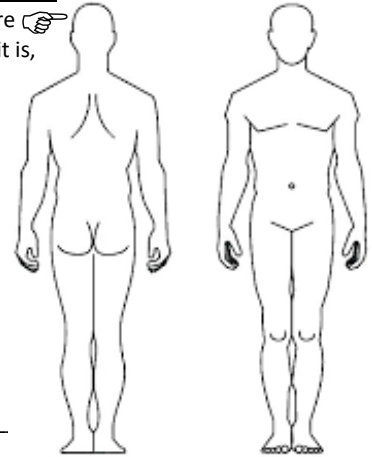
Have you had this condition in the past?  Yes  No

Have you seen anyone else regarding this condition?  Yes  No

If yes, Who & Where? \_\_\_\_\_

Indicate on the drawing where you are experiencing 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  
ST – Stiffness    O – Other



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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder (RT / LT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upper Back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mid Back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low Back	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Buttocks (RT / LT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip (RT / LT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leg (RT / LT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee (RT / LT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foot (RT / LT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Family & Patient History

Please indicate any family or person history

	Family History		Personal History		
	Yes	No	Current	Past	Never
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Back Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Scoliosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High or Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

# Kelly Chiropractic Patient Health History & Review of Systems

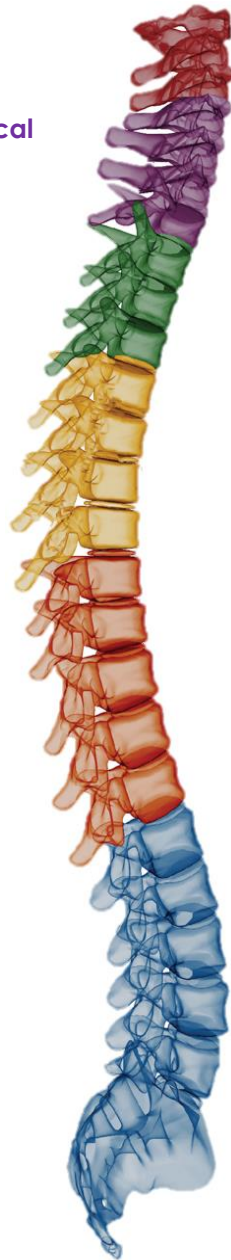
Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

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

## Regions

## Symptoms



**Cervical**

**Upper Thoracic**

**Mid Thoracic**

**Lower Thoracic**

**Lumbar, Sacrum & Pelvis**

Past Present

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Colic & Excessive Crying  
Sinus Infections/Problems  
Headaches / Migraines  
Vertigo  
Sore Throat & Strep  
Swollen Tonsils & Adenoids  
Hearing Loss / Issues  
Eye Sensitivity to Light  
Epilepsy / Seizures  
Sensory & Spectrum  
ADD/ADHD

Past Present

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Focus & Memory Issues  
Balance & Coordination  
Speech Issues  
TMJ / Jaw Pain  
Tremors  
Poor Metabolism & Weight Control  
Dyslexia  
Ear Infections  
Mistake Right from Left  
Head Seems to Heavy  
Head & Shoulders Feel Tired

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Reflux/GERD  
Chronic Colds & Cough

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Bronchitis & Pneumonia  
Functional Heart Conditions

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Gallbladder Pain/Issues  
Jaundice  
Fever  
Hepatitis

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Indigestion & Heartburn  
Stomach Pains & Ulcers  
Liver Trouble

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Behavior Issues  
Kidney Problems  
Excessive Gas

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Hyperactivity  
Losses Temper Easily  
Belching / Bloating after Meals

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Chrohn's, Colitis and/or IBS  
Colon Issues  
Bed Wetting  
Gluten / Casein Intolerance  
Infertility  
Impotency  
Hemorrhoids

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Sciatica & Radiating Pain  
Hamstring Tightness  
Varicose Veins  
Leg Weakness and/or Cramps  
Poor Circulation and/or Cold Feet  
Cramps and/or Menstrual Issues  
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

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## Hospitalizations & Surgeries

Please list all past Hospitalizations & Surgeries

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## Medications, Vitamins & Supplements

Please list all current Medications, Vitamins & Supplements \*

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\* 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 mental health problems?

- No mental health problems  
 IRRITABILITY  
 DEPRESSION  
 DISTURBED SLEEP  
 SUICIDAL THOUGHTS  
 ANXIETY  
 NERVOUSNESS

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 trouble with your vision?

- No visual problems  
 BLURRED VISION  
 DOUBLE VISION  
 VISION LOSS  
 EYE PAIN  
 WEAR GLASSES/CONTACTS

Do you have any symptoms of heart trouble?

- No heart problems  
 CHEST PAIN  
 PALPATATIONS  
 FAINTING  
 SHORTNESS OF BREATH  
 ANKLE SWELLING

Do you have any breathing problems?

- No breathing problems  
 COUGHING  
 WHEEZING  
 SHORTNESS OF BREATH

Do you have any stomach problems?

- No stomach problems  
 NAUSEA  
 VOMITING  
 DIARRHEA  
 CONSTIPATION  
 LOSS OF BOWEL CONTROL

Do you have any muscle or joint problems?

- No muscle or joint problems  
 JOINT PAIN  
 JOINT WEAKNESS  
 MUSCLE WEAKNESS

Do you have any skin problems?

- No skin problems  
 RASH  
 ITCHING  
 DRYNESS  
 LESIONS  
 OPEN WOUND/INFECTION  
 HAIR/NAIL CHANGES

Do you have any immunity problems?

- No immune system problems  
 ENLARGED LYMPH NODES  
 HIVES  
 HAY FEVER  
 PERSISTANT INFECTION

Do you have any endocrine problems?

- No endocrine problems  
 DIABETES  
 THYROID DISORDER

Do you have any neurological problems?

- No neurological problems  
 SEIZURES  
 ABNORMAL SENSORY FEELINGS IN EXTREMITY  
 LOSS OF MEMORY

Do you have any bruising or bleeding problems?

- No bruising or bleeding problems  
 HISTORY OF ANEMIA  
 ABNORMAL BLEEDING  
 BRUISING  
 HEAT INTOLERANCE  
 COLD INTOLERANCE

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?    Do you eat sweets?    Describe your appetite?    Describe your caffeine intake?
- Never     Heavy     Heavy     Heavy  
 Rarely     Moderate     Moderate     Moderate  
 Occasionally     Light     Light     Light  
 Usually     None     None     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?

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Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_