Kelly Chiropractic Patient Information & Health History

Date ____/____/____ Patient #_____

Patient Information

Name: _____

Date of Birth: _____/_____/_____ Age: _____

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? How and when did symptoms appear?

Primary Complaint:

_____

_____

Pain Scale (Please circle the number that best describes the pain level of your primary complaint)

0 1 2 3 4 5 6 7 8 9 10

Additional Complaint(s):

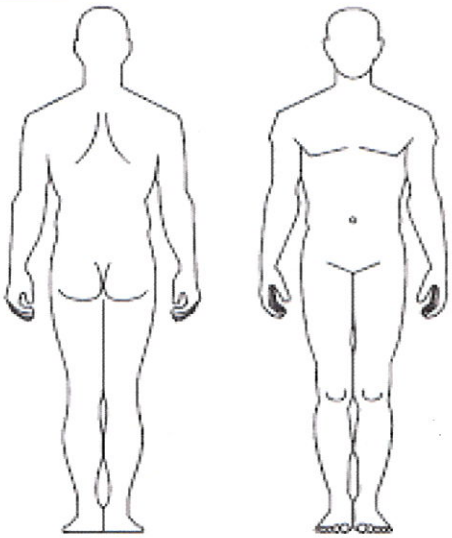
_____

_____

Pain Scale (**Please put the pain scale number next to each additional complaint**)

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 see anyone else regarding this condition? If so, who and where:

_____

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 ____/_____/_____

Kelly Chiropractic Patient Social History

Education

Highest level of education completed

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

_____

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 _____/_____/_____

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:

_____

_____

Have you ever had a significant accident or fall? ◯ Yes ◯ No
If yes, please list indicated when:

_____

_____

Have you ever been knocked unconscious? ◯ Yes ◯ No
If yes, please list indicated when:

_____

_____

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