KLINGERT CHIROPRACTIC

Name: _____ Date: _____

MEDICAL HISTORY

1. How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

2. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

3. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Other _____

□ Heart Problems □ Cancer □ ALS

4. List all prescription medications you are currently taking:

_____ _____ _____

_____ _____ _____

5. List all of the over-the-counter medications and nutritional supplements you are currently taking:

_____

6. List all surgical procedures / hospitalizations you have had and include year:

_____ _____

_____ _____

7. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

8. What activities do you do outside of work?

_____

9. Have you had significant past trauma? □ No □ Yes If yes, please list each occurrence:

_____

_____

10. Anything else pertinent to your visit today? _____

SMOKING STATUS: Smokes Every Day Smokes Some Days Former Smoker Never Smoked

Please circle: White American Indian Asian Hispanic; Preferred Language _____

Preferred Method of Contact: Phone Email Mail _____

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Name: _____ File#: _____

12. Have you been under chiropractic care before? **No / Yes** **Date of last adjustment** _____

Name & Address of Chiropractor: _____

Date of Last X-rays: _____

Results of Treatment? □ Good □ Mixed □Poor

12. What do you expect from your Chiropractor?

□ Give temporary relief. □ Resolve the pain.

□ Resolve the pain and stabilize the causation of the problem.

□ Other _____

13. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past / Present		Past / Present		Past / Present	
□ / □	Headaches	□ / □	High Blood Pressure	□ / □	Diabetes
□ / □	Neck Pain	□ / □	Heart Attack	□ / □	Excessive Thirst
□ / □	Upper Back Pain	□ / □	Chest Pains	□ / □	Frequent Urination
□ / □	Mid Back Pain	□ / □	Stroke	□ / □	Tobacco Use
□ / □	Low Back Pain	□ / □	Angina	□ / □	Drug/Alcohol Use
□ / □	Shoulder Pain	□ / □	Kidney Stones	□ / □	Allergies
□ / □	Elbow/Up. Arm Pain	□ / □	Kidney Disorders	□ / □	Depression
□ / □	Wrist Pain	□ / □	Bladder Infection	□ / □	Systemic Lupus
□ / □	Hand Pain	□ / □	Painful Urination	□ / □	Epilepsy
□ / □	Upper Leg Pain	□ / □	Loss of Bladder Control	□ / □	Dermatitis
□ / □	Knee Pain	□ / □	Prostate Problems	□ / □	Tumor
□ / □	Hip Pain	□ / □	Cancer	□ / □	HIV/AIDS
□ / □	Ankle/Foot Pain	□ / □	Abnormal Weight Gain/Loss	□ / □	Loss of Appetite
□ / □	Eczema/Rash	□ / □	Asthma	□ / □	Visual Disturbances
□ / □	Chronic Sinusitis	□ / □	Muscular In-coordination	**For Females Only**	
□ / □	General Fatigue	□ / □	Liver/Gall Bladder Disorder	□ / □	Birth Control Pills
□ / □	Jaw Pain	□ / □	Abdominal Pain	□ / □	Hormonal Replacement
□ / □	Joint Pain/Stiffness	□ / □	Ulcer	□ / □	Pregnancy
□ / □	Arthritis	□ / □	Hepatitis	____	# of Pregnancies
□ / □	Rheum. Arthritis	□ / □	Dizziness	____	# of Children
□ / □	Other:_____			____	# of Miscarriages

14. Drug Allergies: _____

I hereby state that the information on this form is true and correct. I authorize the Doctors at the Center to examine, take x-rays and treat me for the care and management of my condition.

Patient Signature_____ **Date:**_____

I hereby give permission to administer treatment as deemed necessary for the care of my child,

(*Print child's name*) _____ Birthdate: _____ Parent's Signature: _____