

Kauffman-Hummel Chiropractic Clinic

NEW PATIENT INFORMATION

Name: _____ Patient ID# _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Age: _____

Cell Phone: _____ Social Security #: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Work Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone: _____

Occupation: _____ Employer: _____

How did you hear about us?

____ Referral (Who?) _____

____ Spinal Screening (Where?) _____

____ Health Fair (Where?) _____

____ Yellow Pages ____ Insurance Directory ____ Sign Outside ____ Magazine

Current Complaint:

Reason for your visit: _____

Where does it hurt (i.e., leg, back, arm, etc.)? _____

How did it start? _____ How long have you had this problem? _____

Have you had a similar condition in the past? Yes No

If yes, when? _____

What kind of pain is it? (Circle any that apply)

Burning / Sharp / Shooting / Dull / Achy / Nagging / Electric Shocking / Zapping

Does the pain stay in that spot? Yes No

Or does it radiate? Yes No

If it radiates, where does it go? _____

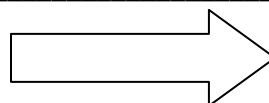
Are your symptoms constant? Yes No Or do they come and go? Yes No

If come and go, do they come and go every day, 2-3 times per week, or 1 time per week, or 2-3 times per month? _____ How long does it last when they come? _____

What have you done for this problem? _____

Does it make it better or worse? _____

TURN OVER AND COMPLETE BACK OF FORM



Other Complaints:

Any other health problems?:

Headaches.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Neck pain.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mid-back pain.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Upper-back pain.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lower-back pain.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Numbness/Tingling.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, where? _____

Any pain in your body, anywhere, when you:

Cough.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sneeze.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Go to the bathroom..... (like bearing down for a bowel movement)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Medical Information:

What medications are you presently taking?
(If you have a list, can we have a copy of it?)

Have you had any surgeries?
(If you have a list, can we have a copy of it?)

Have you been diagnosed with cancer?..... Yes No

Your Medical Doctor's Name: _____

What is the Name of his/her Office? _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Date of last visit there: _____ Reason: _____

Have you ever been involved in an auto or work accident?..... Yes No
If yes, when? _____

Miscellaneous:

Do you drink?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you do drugs?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you smoke?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If yes, how much, how often and for how long (i.e., pack a day for 10 years).

(Continued...)

Do you have a family history (parents, grandparents, siblings or children) with any of the following?

Heart attacks..... Yes No

Strokes..... Yes No

Cancers..... Yes No

Diabetes..... Yes No

If yes to any, list what and who:

Have you ever been to a chiropractor before?..... Yes No

If yes, who and how long since last adjustment?

Any X-rays taken at this office will remain the property of this office. If you need them, they may be borrowed for a specific amount of time.

I authorize Kauffman Hummel Chiropractic Clinic to release the information to my insurance company for payment if it is used. I authorize the release of information to Kauffman Hummel Chiropractic Clinic from other facilities regarding treatment. The above statements are true to the best of my knowledge.

Patient Signature: _____ **Date:** _____

*****Please give Receptionist your health insurance card to be copied*****