CONFIDENTIAL HEALTH INFORMATION

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Please allow our staff to copy your insurance cards.
All information you supply is confidential.
Please print clearly.

Todays Date:_____ Patient I.D._____

CHIROPRACTIC HISTORY

Have you consulted a chiropractor before? _____ When?:_____

If so, whom?_____

PERSONAL INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Birth Date: _____ Age: _____ Sex:◉M○F

Cell Phone: _____ E-Mail Address: _____

Social Security #_____ Language: _____ Race:_____

Circle One: ◉ Married ○ Single ○ Widowed ○ Divorced ○ Separated

Employer: _____ Type of Work: _____

Business Phone: _____

Whom may we thank for referring you?: _____

Name of Emergency Contact: _____ Phone #_____

Smoking Status ◉ Current Smoker ○ Former Smoker ○ Never Smoked

INSURANCE INFORMATION

Health Insurance Carrier: _____ Policy Number:_____

Who is the primary insured? _____ Primary insured birthdate: _____

Relationship to patient. _____ Is patient covered by additional insurance? If yes…

2nd Insurance Co. Name_____

Subscriber's Name_____ Relationship to patient_____

CURRENT MEDICATIONS AND ALLERGIES

Current Medications (Please list all use additional paper if needed.)_____

_____

Current Medication Allergies_____

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Patient ID # _____

Patient Name_____

All information you supply is confidential.
Please print clearly.

1. The symptoms that have prompted me to seek care today include:_____

_____

2. Is condition: ○ Job Related ○ Auto Accident ⊙ Home Injury ○ Fall Other:_____

3. When did this condition begin? _____

4. Has this condition occurred before? ○ Yes ⊙ No

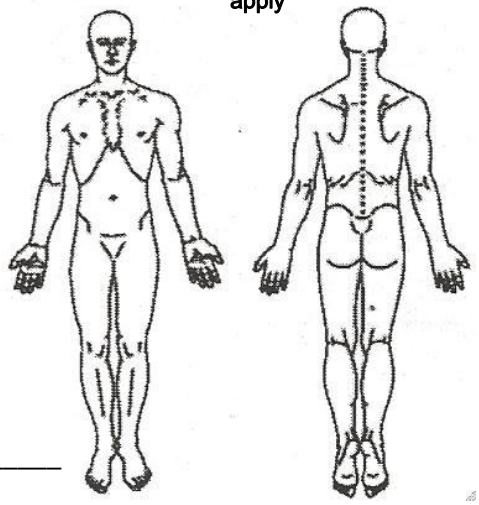
5. How extreme are your current symptoms **0** ○ ○ ○ ○ ⊙ ○ ○ ○ ○ ○ **10**
Absent Uncomfortable Agonizing

6. When did it start and how often do you feel it? ⊙ Constant ○ Comes and goes. How Often? _____

7. What does it feel like?

Numbness
Tingling
Stiffness
Aching
Cramps
Nagging
Sharp
Burning
Shooting
Throbbing
Stabbing
Other _____

8. Where does it hurt? Click on all areas that apply



9. Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel

_____

10. What makes it better or worse, such as time of day, movements, certain activities, etc.

What tends to worsen the problem?_____

_____

What tends to lessen the problem?_____

_____

10. What have you done to relieve the symptoms?
Click all that apply

Prescription medication	Surgery	Ice
Over the counter drugs	Acupuncture	Heat
Homeopathic remedies	Chiropractic	Other_____
Physical therapy	Massage	_____

11. What else should Dr. Kempton know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.
Click the box to 'check mark' whether you have HAD or HAVE any of these symptoms.

a. Musculoskeletal NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Osteoporosis			Shoulder problems			Scoliosis			Back problems			Neck pain			Hip disorders
Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Knee Injuries			Foot/ankle pain			Arthritis			Elbow/wrist pain			TMJ issues			Poor posture

b. Neurological NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Anxiety			Depression			Headache			Pins and needles			Dizziness			Numbness

c. Cardiovascular NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		High blood pressure			Low blood pressure			Angina			High cholesterol			Poor circulation			Excessive bruising

d. Respiratory NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Asthma			Shortness of breath			Apnea			Emphysema			Hay fever			Pneumonia

e. Digestive NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Anorexia/bulimia			Food sensitivities			Ulcer			Constipation			Heartburn			Diarrhea

f. Sensory NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Blurred vision			Ringing in ears			Hearing Loss			Chronic ear infections			Loss of smell			Loss of taste

g.Integumentary NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Skin cancer			Psoriasis			Eczema			Acne			Hair loss			Rash

h. Endocrine NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Thyroid issues			Immune disorders			Frequent Infection			Hypoglycemia			Swollen glands			Low energy

i. Genitourinary NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Kidney stones			Infertility			PMS Symptoms			Bedwetting			Prostate issues			Erectile dysfunction

j. Constitutional NONE

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
		Fainting			Sudden weight gain or loss			Fatigue			Poor appetite			Low libido			Weakness

14. Check the illnesses you have **Had** in the past or **Have** now

Had	Have		Had	Have		Had	Have		Had	Have	
		AIDS			Diabetes			Hepatitis			Polio
		Alcoholism			Epilepsy			HIV Positive			Rheumatic fever
		Allergies			Glaucoma			Malaria			Scarlet fever
		Arteriosclerosis			Goiter			Measles			Stroke
		Cancer			Gout			Multiple Sclerosis			Tuberculosis
		Chicken pox			Heart disease			Mumps			Ulcer

Other:_____

15. Check any surgeries, which may or may not have included hospitalization.

Appendix removal	Eye surgery	Tonsillectomy
Bypass surgery	Hysterectomy	Vasectomy
Cancer	Pacemaker	Other_____
Cosmetic surgery	Spine _____	_____
Elective surgery_____	_____	_____
_____	_____	_____

16. Check any treatments you have received in the **Past** or are receiving **Currently**.

Past	Current		Past	Current		Past	Current		Past	Current	
		Acupuncture			Chemotherapy			Homeopathy			Physical Therapy
		Antibiotics			Chiropractic care			Hormone replacement			Nutrition
		Birth Control Pills			Dialysis			Inhaler			List_____
		Blood transfusions			Herbs			Massage therapy			_____

17. Injuries, have you ever…

Had a fractured or broken bone	Used a crutch or other support
Had a spine or nerve disorder	Used neck or back bracing
Been knocked unconscious	Received a tattoo
Been injured in an accident	Had a body piercing

18. Some health issues are hereditary. Tell Dr. Kempton about the health of your immediate family members.

Relative	**Age**	**State of health**			**death**	**Cause of death**	
		Good	**Poor**			**Natural**	**Illness**
Mother	_____			_____	_____		
Father	_____			_____	_____		
Sister 1	_____			_____	_____		
Sister 2	_____			_____	_____		
Brother 1	_____			_____	_____		
Brother 2	_____			_____	_____		
_____	_____			_____	_____		

19. Are there any other hereditary health issues that you know about? _____

20. Tell Dr. Kempton about your health habits and stress levels.

Alcohol use	Daily	Weekly	How much? _____	Prayer or meditation?	Yes	No
Coffee use	Daily	Weekly	How much? _____	Job pressure/stress?	Yes	No
Tobacco use	Daily	Weekly	How much? _____	Financial peace?	Yes	No
Exercising	Daily	Weekly	How much? _____	Vaccinated?	Yes	No
Pain relievers	Daily	Weekly	How much? _____	Mercury fillings?	Yes	No
Soft drinks	Daily	Weekly	How much? _____	Recreational drugs?	Yes	No
Water Intake	Daily	Weekly	How much? _____			

Hobbies _____

21. How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting					Grocery shopping				
Rising out of chair					Household chores				
Standing					Lifting objects				
Walking					Reaching overhead				
Lying down					Showering or bathing				
Bending over					Dressing myself				
Climbing stairs					Love life				
Using a computer					Getting to sleep				
Getting in/out of a car					Staying asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				
Caring for family					Yard work				

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____**Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What is the most significant thing that you could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care: care in which the goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting

Check Here if you want the Doctor to select the type of care appropriate for your condition.

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, he or she deems appropriate and that can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____ I also understand the amount paid the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen anytime while a patient at this office.

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

Initials _____ I understand and agree that insurance policies are an arrangement between the carrier and me and that I am responsible for any covered or non-covered charges. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Signature Date

If the patient is a minor child, print child's full name:_____