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?____

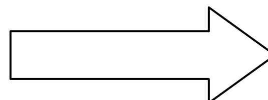
What kind of pain is it? (Circle any that apply)
Burning / Sharp / Shooting / Dull / Achy / Nagging / Electric Shocking / Zapping

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 No

Neck pain………………………………………………………………………….. Yes No

Mid-back pain…………………………………………………………….……….. Yes No

Upper-back pain………………………………………………………………….. Yes No

Lower-back pain………………………………………………………………….. Yes No

Numbness/Tingling…………………………………………………………..…. Yes No

If yes, where?____

Any pain in your body, anywhere, when you:

Cough……………………………………………………………………...……. Yes No

Sneeze…………………………………………………………………….…. Yes No

Go to the bathroom……………………………………………………………. Yes No

(like bearing down for a bowel movement)

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? When?
(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 No

Do you do drugs?……………………………………………………………… Yes No

Do you smoke?……………………………………………………………… Yes No

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