WELCOME TO KRUSE CHIROPRACTIC

208 EAST MILL STREET
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PERSONAL INFORMATION

First: _____ **Last:**_____**Preferred Name**: _____

Birth Date:_____/___/_____ **Sex:** ☐ Male ☐ Female **SSN:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Cell Phone: _____ Secondary Phone: _____ Email: _____

Emergency Contact:_____**Relation:** _____ **Phone**: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **# of Children:** _____

Primary Physician Name: _____**Phone number:** _____

Occupation: _____**Employer:** _____

Referred By? ☐ Online ☐ Family ☐ Friend ☐ Close to home/work ☐ Physician ☐ Other: _____

SOCIAL HISTORY

How often do you exercise? ☐ Never ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week

What does your exercise routine consist of? _____

Smoking Status: ☐ Non-smoker ☐ Current Smoker ☐ Former Smoker

How many years have or did you smoke? _____Number of packs per day?_____When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week: _____ **Recreational drug use?** Y / N

Number of caffeinated beverages per day: _____ **How much water do you drink per day?** _____

REVIEW OF SYSTEMS

Please mark whether you have problems with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Weight Loss	☐	☐	High Blood Pressure	☐	☐	Asthma/Chronic Cough	☐	☐	Change Bowel /Bladder Function
☐	☐	Fever or Chills	☐	☐	Anemia	☐	☐	Difficulty Swallowing	☐	☐	Constipation or Diarrhea
☐	☐	Vision or Hearing Changes	☐	☐	Bleeding Disorders	☐	☐	Nausea or Heartburn	☐	☐	Change in Urinary Frequency
☐	☐	Sinus Problems	☐	☐	Autoimmune Disease	☐	☐	Change in Appetite	☐	☐	Burning or Pain with Urination
☐	☐	Sore Throat	☐	☐	Cancer	☐	☐	Jaw Pain/TMJ Problems	☐	☐	Incontinence
☐	☐	Mouth Sores	☐	☐	Prostate Problems	☐	☐	Arthritis	☐	☐	Blood in Urine or Stool
☐	☐	Chest Pain or Discomfort	☐	☐	Thyroid Problems	☐	☐	Bone Fractures/Dislocations	☐	☐	Epilepsy/Seizures/Fainting
☐	☐	Shortness of Breath	☐	☐	Heat or Cold Intolerance	☐	☐	Osteoporosis	☐	☐	Anxiety/Depression
☐	☐	Heart Palpitations	☐	☐	Frequent Urination or Thirst	☐	☐	Rashes, Itching or Dry Skin	☐	☐	Memory Loss
☐	☐	Swelling of Limbs	☐	☐	Diabetes (Type I or Type 2?)	☐	☐	Hair or Nail Changes	☐	☐	Difficulty Sleeping
☐	☐	Stroke	☐	☐	Fibromyalgia	☐	☐	Dizziness	☐	☐	Allergies

MEDICAL HISTORY

Please list any other serious conditions or illnesses you currently or ever had. _____

_____

Please list any accidents, injuries or traumas you have experienced with dates. _____

_____

Please list ALL surgeries and hospitalizations. _____

_____

List any known allergies, including drug allergies and the reaction you experience. _____

_____

Please list <u>ALL</u> medications you are taking. _____

_____

FEMALES ONLY: Are you currently pregnant? ☐ Yes ☐ No Have you ever given birth? ☐ Yes ☐ No # of Kids: _____

FAMILY MEDICAL HISTORY

Please indicate if any of the following family member(s) has arthritis, cancer, diabetes, high blood pressure, stroke, heart problems, genetic disorders, mental health issues or any other serious health issues in the chart below.

Father	Mother	Grandfather	Grandmother	Sibling	Children

REASON FOR VISIT

What is the reason for your visit today? ☐ Headaches ☐ Neck Pain ☐ Lower Back Pain
☐ Mid-Back Pain ☐ Upper Back Pain ☐ Other _____

Does the pain radiate, shoot or travel anywhere? ☐ Yes ☐ No **If so, where? ___ When did this start?** _____

_____**How did this start?** _____

Since it started, my symptoms have been getting: ☐ Worse ☐ Better ☐ Staying the same

My symptoms are present: ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

Have you had any other recent treatment for this condition? ☐ Yes ☐ No

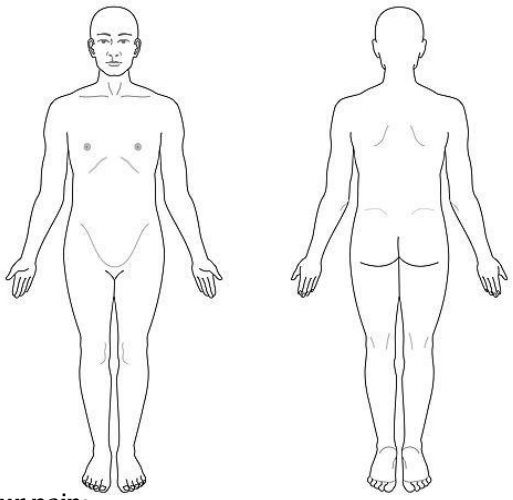
Doctor's Name: _____ Treatment: _____

Have you had the same or similar problems in the past? ☐ Yes ☐ No Treatment: _____

What do your symptom(s) feel like?

☐ Sharp	☐ Sore	☐ Spasms	☐ Stabbing	☐ Tingling
☐ Dull	☐ Tight	☐ Shooting	☐ Throbbing	☐ Numbness
☐ Aching	☐ Stiff	☐ Cramping	☐ Burning	☐ Other:

Please circle or mark on the body diagram to indicate where you are having pain and/or symptoms.



What aggravates your symptoms?

☐ Sitting	☐ Driving	☐ Lifting
☐ Standing	☐ Getting up from chair	☐ Bending
☐ Laying down	☐ Stair climbing	☐ Twisting
☐ Walking	☐ Inactivity/Sleeping	☐ Reaching
☐ Running	☐ Desk Work	☐ Sneezing/Coughing
☐ Physical Activity	☐ Housework	☐ Stress
☐ Exercise	☐ Personal Hygiene	☐ Other:

What relieves your symptoms?

☐ Rest/Sleeping	☐ Medication	☐ Ice or Heat
☐ Sitting or Standing	☐ Stretching	☐ Nothing
☐ Massage	☐ Exercises/ PT	☐ Other:

Rate your pain:
0 1 2 3 4 5 6 7 8 9 10

Symptoms are the most severe:

☐ In the Morning	☐ In the Afternoon	☐ In the Evening
☐ During Activities	☐ After Activities	☐ Sleeping
☐ Symptoms do not change		☐ Other:

This condition is interfering with my:

☐ Personal Hygiene	☐ Housework
☐ Daily Routine	☐ Social Activities
☐ Work Activities	☐ Mobility

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- Financial agreement between Kruse Chiropract, LLC and patient: I understand the following: I am responsible to pay all fees at the time of service. If there is a balance rendered, the balance is to be paid within 30 days or a $5 charge will be added to the amount each month that it goes unpaid. If I am considered a "no show" for my scheduled appointment that I will be responsible for a $25 charge. No service(s) will be rendered free of charge. The doctor may approve a payment schedule if needed.

Signature: _____ **Date:** _____