Kellerman Chiropractic Center

PATIENT PERSONAL INFORMATION

(All Patient Information is kept confidential)

N0. ______________ **Date:** ________________________

Patient Name: ____

Date of Birth: ____________________ **Social Security #:** ________________________

Address: ____

Home Phone: ( )______________ **Work:** ( )______________ **Cell:** ( )_____________

Employer:__________________________ **Occupation:**____________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced (Separated) ☐ Widowed

Spouse: ____________________ **Number of Children:** ________________

How did you learn about Kellerman Chiropractic? ________________________________

Emergency Contact (Name & Number): ____

IF YOU HAVE HEALTH INSURANCE THAT YOU WOULD LIKE FOR US TO BILL PLEASE GIVE YOUR CARD(S) TO THE RECEPTIONIST TO BE COPIED. THANKS!

What is the purpose of your visit today? ____

What is the date that your symptoms began? ____________________________________

Was this do to an accident? ☐Yes ☐No **If yes,** ☐Auto ☐On the Job ☐Other ___________

What makes your condition better? ____________________ **Worse?** _________________

How often do you symptoms occur? ☐Occasional ☐Intermittent ☐Frequent ☐Constant

Are you taking and medications? ☐Yes ☐No If yes, what? _________________________

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Past Surgeries (what & date):____

Do you have a history of cancer? ☐Yes ☐No If yes, please explain ___________________

Do you have a primary care physician? ☐Yes ☐No If yes, Who? _____________________

Patient's (Parent or Guardian) Signature:____

Health Questionnaire

Please check mark each of the conditions below that you are currently experiencing.

Name: ______________________________ **Date:** ______________________

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALES ONLY

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on breast

ARE YOU PREGNANT?
☐ YES ☐ NO

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol abuse
- ☐ Coffee or tea
- ☐ Drug abuse
- ☐ ______________

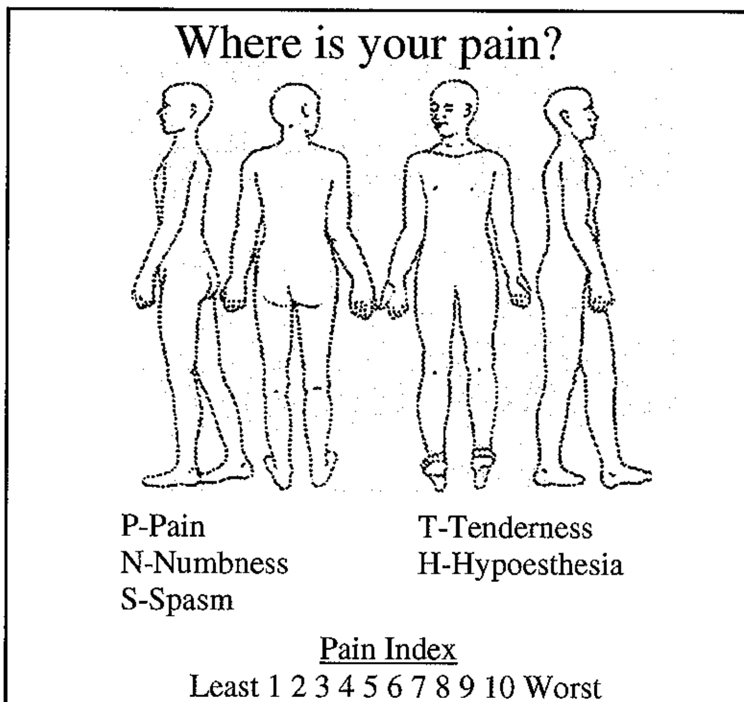
CARDIO-VASCULAR/ RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Varicose veins
- ☐ Lung problems

EYE, EAR, NOSE, AND THROAT

- ☐ Eye Strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose discharge
- ☐ Difficulty breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

Where is your pain?



P-Pain
N-Numbness
S-Spasm
T-Tenderness
H-Hypoesthesia

Pain Index
Least 1 2 3 4 5 6 7 8 9 10 Worst

-------------------- **DO NOT WRITE BELOW THIS LINE** --------------------

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Patient Accepted? ☐ YES ☐ NO **Doctor's Signature** ______________________