Date _____

Please fill out this form in detail.
The information will be used to assist the doctor in best serving you.
This information is confidential and will only be used for clinical purposes.

KINETIC SPINE & SPORT
LIVE LIFE IN MOTION

Patient Information

Name (First, MI, Last) _____ Preferred Name: _____ ☐ Female ☐ Male

Address: _____ Apt./Unit Number _____

City: _____ State: _____ Zip Code: _____

Parent's Name(s):_____ Best Contact #: _____

Email: _____ Birth Date: _____ SSN: _____ - _____ - _____

School: _____ School's City, State _____

How were you referred to Kinetic Chiropractic?

☐ Family Member ☐ Friend ☐ Doctor ☐ Internet ☐ Phone Book ☐ Other _____

Please list the name of the family member, friend or doctor that referred you: _____

Have you been to a chiropractor before? ☐ No ☐ Yes Approximate Date of Last Visit _____

Reason for Today's Visit

Chief complaint _____

How long ago did your symptoms begin? _____ Have you had this problem before? ☐ Yes ☐ No

How did this problem start? _____

Is the problem related to an auto accident? ☐ No ☐ Yes If yes, what is the date of the accident? _____

Describe your current pain: ☐ Dull Ache ☐ Sharp / Stabbing ☐ Numb/Tingles

Average pain intensity: (circle one) 0 1 2 3 4 5 6 7 8 9 10

Overall, my condition is: ☐ Getting Worse ☐ Getting Better ☐ Staying the Same

How frequently do your symptoms occur?

☐ Constant (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (0-25% of the time)

How much does your condition interfere with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, you would say your overall health right now is…

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What makes it better? _____

What makes it worse? _____

Have you seen anyone else for this condition? ☐ Yes ☐ No

If Yes, who? _____

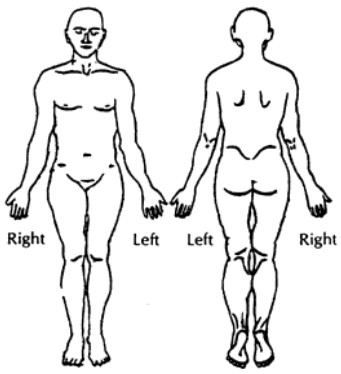
Type of treatment(s) tried _____

Results: _____

Secondary complaint (if applicable) _____

_____

Please mark all areas of concern.



FOR OFFICE USE ONLY:

_____
_____
_____
_____
_____
_____
_____

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General Health History

Please indicate if you have or have had any of these conditions

Past	Present		Past	Present		Past	Present	
☐	☐	Scoliosis	☐	☐	Bronchitis	☐	☐	Cancer _____
☐	☐	Headaches / Migraines	☐	☐	Shortness of Breath	☐	☐	Diabetes
☐	☐	Dizziness	☐	☐	Asthma / Allergies	☐	☐	Depression / Anxiety
☐	☐	Numbness	☐	☐	Wheezing	☐	☐	Irritable / Temper Tantrums
☐	☐	Fainting	☐	☐	Frequent Sore Throat			
☐	☐	Poor Appetite	☐	☐	Frequent Colds			
☐	☐	Feeding/Eating Problems	☐	☐	Bed Wetting			
☐	☐	Chronic Constipation	☐	☐	Toilet Training Problems			
☐	☐	Chronic Diarrhea	☐	☐	Difficult/Pain Urination			
☐	☐	Dental or Jaw Problems	☐	☐	Trouble Sleeping			
☐	☐	Hearing Problems	☐	☐	Vision Problems			
☐	☐	Other _____						

For Children Ages 3 and under:

_____		Child's Weight at birth
❑Vaginal	❑C-Section	Delivery Method
Yes	No	Forceps or vacuum used?
Yes	No	Born more than 2 weeks early?
Yes	No	Born more than 2 weeks late?
Yes	No	Was / Is the child breastfed?
_____		Age breastfeeding discontinued

Current Health Status

Do you take any medications or vitamins? ☐ No ☐ Yes

If yes, please list: _____

_____

Do you have any known allergies? ☐ No ☐ Yes

If yes, please list: _____

_____

Please list any past accidents / injuries: _____

_____

Please list any previous surgeries: _____

_____

Family History

Father: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Mother: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____

Patient Name _____ Date _____