Krieser Chiropractic
Family Wellness Center

New Patient History Form

Today's Date____/____/___

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ DOB: _____S/S_____-_____-_____
First MI Last

Address_____ City_____ State_____ Zip_____

Please check your preferred method of contact. Is it Ok to leave a message on the preferred number ❒*Yes* ❒*No*

❒Home Phone_____ ❒Work Phone_____

❒Cell Phone_____ ❒e-mail address:_____

Would you like to receive appointment reminders? ❒ NO ❒YES Preferred Method: ❒Phone call ❒ Text ❒ E-mail

Height_____ Weight_____ Last known Blood Pressure: _____ *(Unsure? We can take a reading today)*

Do you smoke: ❒ No❒ Yes (If yes how often_____) If you quit: Start date: _____ End Date: _____

Sex: ❒ Female ❒ Male **Status:** ❒ Minor ❒Married ❒Single ❒ Other: _____

Ethnicity / Race: _____ Employed: ❒Full-Time ❒Part-Time ❒Student

Your Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

Whom may we thank for referring you to us? _____

Person to contact in case of an emergency_____ Phone_____

HEALTH HISTORY

Past	Present		Past	Present		Past	Present	
____	____	Headaches	____	____	Sleeping Problems	____	____	Painful Urination
____	____	Neck Pain	____	____	Fatigue	____	____	Urinary Problems
____	____	Neck Stiffness	____	____	Depression	____	____	Kidney Stones
____	____	Mid Back Pain	____	____	Nervousness	____	____	Upset Stomach
____	____	Low Back Pain	____	____	Cold Sweats	____	____	Abdominal Pain
____	____	Arm Pain	____	____	Fever	____	____	Constipation
____	____	Leg Pain	____	____	Angina	____	____	Diarrhea
____	____	Pins & Needles - Arms	____	____	Chest Pain	____	____	Heartburn
____	____	Pins & Needles - Legs	____	____	Shortness of Breath	____	____	Ulcers
____	____	Numbness in Fingers	____	____	Fainting	____	____	Allergies
____	____	Numbness in Toes	____	____	Dizziness	____	____	Dermatitis/eczema/rash
____	____	Cold Hands	____	____	Loss of Balance	____	____	Asthma
____	____	Cold Feet	____	____	Light Sensitivity- Eyes	____	____	Chronic Sinusitis
____	____	Varicose Veins	____	____	Ringing/Buzzing- Ears	____	____	Hot flashes
____	____	Tension	____	____	Loss of Memory	____	____	Menstrual Pain
____	____	Irritability	____	____	Loss of Smell	____	____	Menstrual Irregularity
____	____	Mood Swings	____	____	Loss of Taste	____	____	Other _____

Have **YOU** (X) or **A FAMILY MEMBER** (F) ever been diagnosed with any of the following conditions**:**

_____Heart Disease ____ Cancer _____Diabetes _____High Blood Pressure _____Stroke

____ Blood clotting disorder _____Hepatitis _____ Other _____

Rate your stress level: ___Little or No Stress ___ Minimal Stress ___ Moderate Stress ___ Highly Stressed

Continued on back...

Do you have any other health concerns or goals that you would like to address? Yes/No If yes, please explain:

_____

_____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

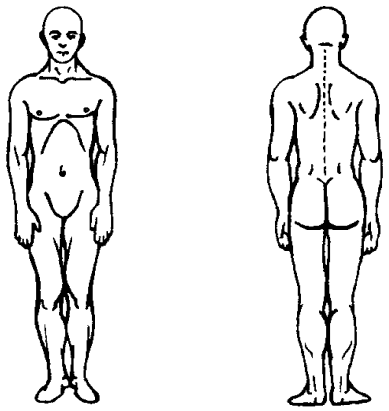
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



When did your symptoms begin? _____How did your symptoms begin? _____

Is your condition changing? ❒No Change ❒Getting Better ❒Getting Worse

When are your symptoms worse? ❒Morning ❒ Afternoon ❒Evening

❒Increase during the day ❒ Improve during the day ❒ Same All Day

Does anything provide relief?_____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down Other: _____

How often do you notice your symptoms? (please indicate one)

❒ Constantly (76-100%of the day) ❒Frequently (51-75%) ❒Occasionally (26-50%) ❒Intermittently (0-25%)

How much does pain interfere with your normal work? (Work and home)

Not at all A little bit Moderately Quite a bit Extremely

How much of the time has your condition interfered with social activities?

All of the time Most of the time Some of the time A little of the time None of the time

Have you had this problem before? No Yes When?_____

What treatment did you receive? ❒None ❒Chiropractic ❒Medical ❒Physical Therapy ❒Massage ❒Other_____

How would you rate your overall health? ❒ Excellent ❒Very Good ❒Good ❒ Fair ❒ Poor

Have you ever visited a Chiropractor before? No Yes How was your experience? _____

I am currently taking the following medications for the following reasons (include dosage if known):

_____

_____

List Allergies: _____

Surgical History: _____

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

DATE: _____/_____/_____ **SIGNATURE**: _____

PARENT/ GUARDIAN:_____