Kloor Chiropractic & Wellness Center, LLC

Name_____Date_____

Address_____City_____State_____Zip_____

Cell Phone (_____)_____Home Phone (_____)_____Work Phone (____)_____

E-Mail Address_____Social Security #_____

Date of Birth_____ Age (_____) Gender: ☐Male ☐Female ☐Other

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐I decline to answer

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐White(Caucasian)
☐Native Hawaiian/Pacific Islander ☐Other ☐I decline to answer

Preferred language_____

Occupation_____Employer_____

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

Spouse's Name_____Spouse's Occupation _____

Number of Children & Ages_____

Who may we thank for referring you?_____

Have you ever received Chiropractic Care? ☐Yes ☐No

If yes, how long has it been since your last visit?_____

Insurance Company_____ Policy #_____ Group #_____

Policy Holder's Name_____ Relationship to Patient_____

Policy Holder's Date of Birth_____Policy Holder's Social Security #_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign
Name of Insurance Company
directly to Kloor Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. The above-named entity may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Please print name of Patient, Parent or Guardian Relationship to Patient

Kloor Chiropractic & Wellness Center, LLC

Let us extend a warm welcome to you on behalf of the entire Kloor Chiropractic family. Our goal is to provide you with the finest health care possible. To reach this goal it is vital that you are well informed when it comes to your health so that you can be an active participant in the healing process. This participation during the course of care will positively affect your ability to reach your personal health goals. Your participation will also be useful in making decisions about your health for the rest of your life.

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values.

□ **Symptom Relief.** I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.

□ **Prevention.** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

□ **Maintaining Health.** I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.

□ **Family Health.** I take an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health.

Reason for Your Visit Today?_____

On what date did you become aware of this problem?_____

The problem can be described as: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Ache

☐Burning ☐Stiffness ☐Shooting ☐Other_____

Please rate the problem on the following scale. **Mild** 0--1--2--3--4--5--6--7--8--9--10 **Severe**

What makes the problem Better?_____Worse?_____

Since your problem started is it: ☐About the same ☐Getting worse ☐Getting better

Is this problem worse during certain times of the day? ☐Yes ☐No

Is the problem: ☐Constant ☐Frequent ☐Intermittent ☐Occasional

Has this problem affected your: ☐Work ☐Sleep ☐Daily routine ☐Hobbies/Recreation

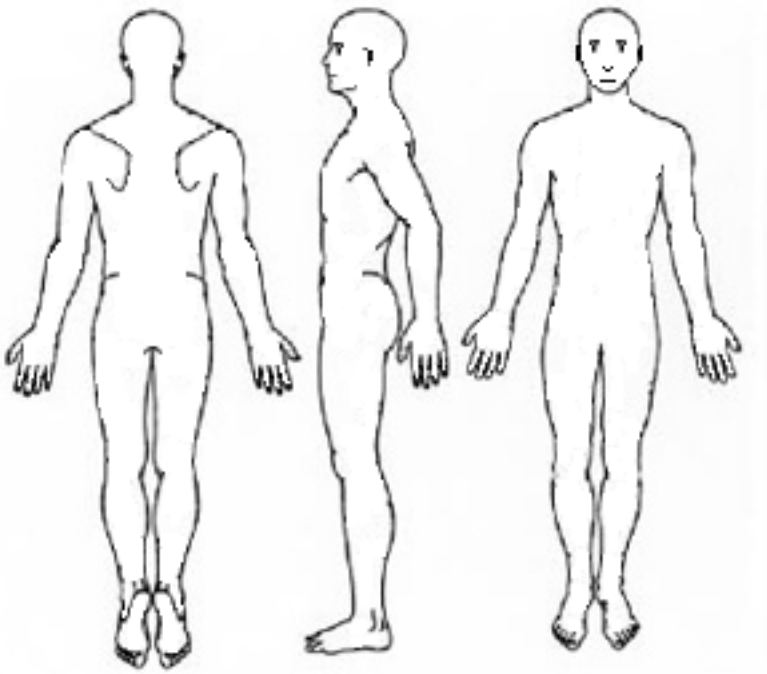
Have you had this or similar problems before? ☐Yes ☐No

Any previous treatment for this problem (including over the counter medications)? ☐Yes ☐No

(If yes, what did you do and what was the result) _____

_____

Please indicate where your problem is on the following diagram.



Health History

General Symptoms
☐Dizziness
☐Light headed
☐Fever
☐Anxiety
☐Unexplained weight loss/gain
☐Insomnia

Musculoskeletal
☐Pain/swelling in the Joints
☐Pain or cramping in the muscle
☐Muscle weakness
☐Muscle spasm/cramps
☐Broken bones
☐Osteoporosis
☐Neck Pain
☐Mid back pain
☐Low back pain
☐Other_____

Neurological
☐Numbness/tingling
☐Recurring headaches
☐Convulsions/seizures
☐Tremors
☐Stroke
☐Previous head injury
☐Imbalance
☐Vertigo
☐Other_____

Ear/Nose/Throat
☐Nasal congestion
☐Sinus/Allergy problem
☐Sore throat
☐Difficulty swallowing
☐Ringing in ears
☐Hearing loss
☐Ear ache or drainage
☐Nose bleeds
☐Dental problems
☐Other_____

Cardiovascular
☐Irregular heartbeat
☐Swelling in hands/ ankles/feet
☐Blood pressure issues
☐Chest pains
☐Other_____

Respiratory
☐Shortness of breath
☐Cough dry/productive
☐Wheezing/Asthma
☐Chest pain
☐Other_____

Gastrointestinal
☐Heartburn
☐Food allergies
☐Change in appetite
☐Constipation
☐Diarrhea
☐Abdominal pain
☐Other_____

Genitourinary
☐Painful urination
☐Kidney stones
☐Sexual dysfunction
☐Frequent urination
☐Incontinence
☐Change in force/strain with urination
☐Other_____

Integumentary
☐Easy bruising/bleeding
☐Rashes/Itching
☐Nail/Hair changes
☐Non-healing wound

Endocrine
☐Thyroid issues
☐Diabetes
☐Heat/cold intolerance
☐Immune system disorder
☐Other_____

Are you pregnant or nursing? ☐Yes ☐No
Please list any surgeries(include year)_____
_____
Please list any accidents or injuries(include year)_____
_____

Lifestyle

Exercise: ☐None ☐Moderate ☐Daily ☐Heavy
Work Activity: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor
Daily Stress Level: ☐Light ☐Moderate ☐High
Smoking status: ☐ Every day ☐Occasional ☐Former ☐Never Smoked Date started_____
Do you drink alcoholic beverages? ☐Yes ☐No (If yes) # of Drinks/Week_____
Do you drink coffee/caffeinated beverages? ☐Yes ☐No (If yes) # of Cups/Day_____
Are you currently taking any medications? ☐Yes ☐No If yes, please list below (use back if needed).

Medication Name	Dosage	Frequency

Do you have any medication allergies? ☐Yes ☐No
If yes, please list and include reaction?_____