Kloor Chiropractic & Wellness Center

Let us extend a warm welcome to you on behalf of the Kloor Chiropractic family. Our goal is the same today as it has been for the last three decades, to guide our patients to health and wellness without the use of harmful drugs or surgery. We work with the cause of pain and dysfunction, not just the symptoms. Please read the descriptions below carefully and mark the ***ONE*** statement that most closely reflects your attitude towards your own healthcare.

☐ **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 occurring or recurring.

☐ **Health Maintenance:** I am aware of how diet, exercise, and stress management affect my health and utilize this awareness to maintain a higher state of health.

☐ **Optimal Wellness:** I am interested in a complete lifestyle of health and wellness. I am concerned with both the short term and long term benefits of living optimally.

Seeking Chiropractic care for pain relief is equivalent to using a smart phone just to make telephone calls. It certainly does the job, but there is so much more to offer if you care to explore. Please fill out the following as accurately and completely as possible to ensure we can provide you with the best care possible.

BASIC INFO

Name	Date	E-Mail Address
Address	City	State & Zip
Date of Birth	Age	Gender ☐ M ☐ F
Cell Phone #	Home Phone #	Work Phone #
Occupation	Employer	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed
Spouses Name	Spouses Occupation	Number of children & Ages
Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino ☐I decline to answer	Race ☐American Indian ☐Asian ☐Black/African American ☐White (Caucasian) ☐Other ☐I decline to answer	
Who may we thank for referring you?	Have you ever received Chiropractic care before? ☐Yes ☐No	If yes, How long since last visit?

INSURANCE

INSURANCE COMPANY	POLICY#	GROUP#
POLICY HOLDERS NAME		
POLICY HOLDERS DATE OF BIRTH		
POLICY HOLDERS SSN:	RELATIONSHIP TO PATIENT:	

☐ I authorize the above insurance company to assign benefits directly to Kloor Chiropractic. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions. The above named entity may use my healthcare information and may disclose such information to 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.

____ _______________

Patient Signature Date

____ _______________

Print Name of Patient or guardian Relation to Patient

HEALTH HISTORY

General Symptoms
☐Dizziness
☐Light Headed
☐Fever
☐Anxiety
☐Unexplained Weight Loss/Gain
☐Insomnia

Musculoskeletal
☐Pain/Swelling in Joints
☐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
☐Loss of Balance
☐Vertigo
☐Other______________

Ear/Nose/Throat
☐Nasal Congestion
☐Allergies
☐Sore Throat
☐Difficulty Swallowing
☐Ringing in Ears
☐Hearing Loss
☐Ear Ache or Drainage
☐Nose Bleeds
☐Dental Problems
☐Other______________

Cardiovascular
☐Irregular Heart Beat
☐Swelling in Hands/Ankles/Feet
☐Blood Pressure Issues
☐Chest Pains
☐Other_____________

Respiratory
☐Shortness of Breath
☐Cough Productive/Dry
☐Wheezing/Asthma
☐Chest Pains
☐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 Wounds

Endocrine
☐Thyroid Issues
☐Diabetes
☐Heat/Cold Intolerance
☐Immune System Disorder
☐Other__________

Are you pregnant or nursing? ☐Yes ☐No
Please list all surgeries (include year)
____
Please list all accidents or injuries (include year if known)
____

LIFESTYLE

Exercise: ☐None ☐Light ☐Moderate ☐Heavy
Work Activity: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor
Daily Stress: ☐None ☐Low ☐Moderate ☐High
Smoking Status: ☐Every Day ☐Occasional ☐Former ☐Never Smoked Started: ________
Do you drink alcoholic beverages? ☐Yes ☐No # of drinks/week________________
Do you drink Coffee/Soda? ☐Yes ☐No # of drinks/day________________
Are you currently taking any medications? ☐Yes ☐No (if yes, list below)

Medication Name	Dosage	Frequency

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

CURRENT COMPLAINT

Reason for visit today?	Date this started?	Progression ☐Same ☐ Getting better ☐Worse
Have you had this or similar problems before? ☐ Yes ☐ No	Any previous treatment? (meds, ice, rest etc…) ☐ Yes ☐ No	Results of previous treatment?
Rate severity using the scale **MILD** 1--2--3--4--5--6--7--8--9--10 **SEVERE**	Rate Quality ☐Sharp ☐Dull ☐Numbness ☐Achy ☐Stiff ☐Shooting ☐ Other	Rate Frequency ☐Constant ☐Frequent ☐Occasional
Has this problem limited your activities? ☐ Work ☐Sleep ☐Daily Routine ☐Hobbies/Recreation	What makes problem better?	What makes problem worse?

Please indicate the site of your problem on the following diagram.