Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Is it okay to call you at work?

❑ Yes ❑ No

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

_____ _____ _____ _____

If you selected 'family member', 'friend', or 'physician' please enter their name below:

_____

If you selected 'other' please describe

_____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionall	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years ❑ Under 10 years ❑ Under 19 years

Female Children:

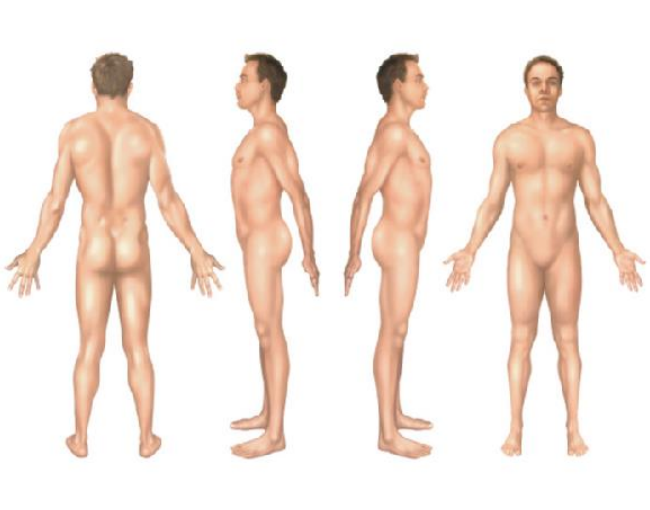
❑ Under 6 years ❑ Under 10 years ❑ Under 19 years

Occupational Activities:

❑ Administration ❑ Business owner ❑ Clerical/secretarial ❑ Computer user
❑ Construction ❑ Daycare/childcare ❑ Executive/legal ❑ Food service industry
❑ Health care ❑ Heavy equipment operator ❑ Heavy manual labor ❑ Home services
❑ Household ❑ Light manual labor ❑ Manufacturing ❑ Medium manual labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:_____

_____

When did your symptoms start? **Month**_____ **Day**_____ **Year**_____

How did your symptoms begin?_____

_____

How often do you experience your symptoms?

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

What describes the nature of your symptoms?

❑ Sharp ❑ Dull ache ❑ Numb ❑ Shooting
❑ Burning ❑ Tingling ❑ Stabbing

How are your symptoms changing?

❑ Getting better ❑ Not changing ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

❑ 0 None ❑ 1 ❑ 2 ❑ 3
❑ 4 ❑ 5 ❑ 6 ❑ 7
❑ 8 ❑ 9 ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

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

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

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

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

❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

Who have you seen for your symptoms:

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What treatment did you receive for your symptoms?

❑ Adjustments ❑ Physical Therapy ❑ Medication ❑ Surgery
❑ Other

When did you receive this treatment?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

What tests have you had for your symptoms?

❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

When were these tests done?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

Have you had similar symptoms in the past?

❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What is your occupation?

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

Kerkhoff Chiropractic's Notice of Privacy Practices

The below named patient acknowledges they have received a copy of Notice of Privacy Practices, and my signature is an acknowledgement that I have read the policy and agree to abide by the same and authorize the office of Paul W. Kerkhoff, D.C. to treat and/or release any medical information necessary to process this claim and request payment of benefits of either to myself or to the party who accepts assignment below.

PATIENT NAME _____
(Please print)

PATIENT SIGNATURE _____

(Parent or legal guardian if patient is under 18 years of age)

DATE_____

Standard Authorization of Use and/or Disclosure of Protected Health Information

I hereby voluntarily authorize Kerkhoff Chiropractic to release any and all medical information, until this authorization is further revoked, to:

_____ Relationship:_____
_____ Relationship:_____
_____ Medical Physician

I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature of Patient: _____
Signature of Patient Representative: _____
Signed and Dated: _____

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Office Policy

Welcome to our office! Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family health care available.

APPOINTMENT SCHEDULING

Dr. Kerkhoff will design a specific course of action to allow proper care for you. It is important for your health to keep all scheduled appointments. If an appointment must be changed, 24 hours notice is requested. All missed appointments should be made up within 24 hours. Occasionally the office is closed while the staff is attending seminars. We will build your schedule around those times.

FINANCIAL AGREEMENT

All payments are expected at time of service. Patient balances may not exceed $200 at any time. Please understand that insurance is no guarantee of payment. All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service or at the beginning of the week. All accounts must be secured with a credit card or paid in full at the time of service. All accounts not paid in 90 days will automatically be put through on your credit card. I waive my right to receive advance notice of the deduction associated with my doctors' services when my account is 90 days past due. There will be a late fee of $35 and 1% interest per month.

Type_____ACCOUNT/CARD #_____EXP.DATE_____

CVV Code: _____

Your payment allows us to continue providing you high levels of professional care. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstanding.

FAMILY & FRIENDS

This office depends upon informed patients to share the Chiropractic message with others. Once you begin experiencing the benefits of Chiropractic we appreciate you sharing the healing benefits with your friends and family.

REMEMBER

Spinal correction and healing take time. If you have questions about your body's responses, please make an appointment to discuss this with Dr. Kerkhoff. We want you to get the most from your chiropractic care.

PRINTED NAME_____

PATIENTS SIGNATURE_____

WITNESS_____DATE_____

REVIEW OF SYSTEMS

CARDIOVASCULAR		PRESENT	PAST	NO
Poor Circulation				
High Blood Pressure				
Aortic Aneurism				
Heart Disease				
Vascular Disease				
Heart Attack				
Chest Pain				
High Cholesterol				
Pace Maker				
Jaw Pain				
Irregular Heart Beat				
Swelling of Legs				
GENITOURINARY		PRESENT	PAST	NO
Kidney Disease				
Lower Side Pain				
Burning Urination				
Frequent Urination				
Blood in Urine				
Kidney Stone				
HEMATOLOGIC/ LYMPHATIC		PRESENT	PAST	NO
Hepatitis				
Blood Clots				

Cancer				
Easy Bruising				
Easy Bleeding				
Fevers/Chills/Sweats				
RESPIRATORY		PRESENT	PAST	NO
Asthma				
Tuberculosis				
Shortness of Breath				
Emphysema				
Cold/Flu				
Couch/Wheezing				
EYES		PRESENT	PAST	NO
Glaucoma				
Double Vision				
Blurred Vision				
EARS/NOSE/THROAT		PRESENT	PAST	NO
Dizziness				
Hearing Loss				
Sinus Infection				
Nosebleed				
Sore Throat				
Difficulty Swallowing				
Bleeding Gums				
INTEGUMENTRAY		PRESENT	PAST	NO

Skin Ulcers				
Skin Disease				
Eczema				
Psoriasis				
Rashes				
ALLERGIC/ IMMUNOLOGIC		PRESENT	PAST	NO
Hives				
Immune Disease				
HIV/AIDS				
Allergy Shots				
Cortisone Use				
GASTROINTESTINAL		PRESEN	PAST	NO
Gallbladder Problems				
Bowel Problems				
Constipation				
Liver Problems				
Ulcers				
Diarrhea				
Nausea/Vomiting				
Bloody Stools				
Poor Appetite				
MUSCULOSKELETAL		PRESNET	PAST	NO
Gout				
Arthritis				

Joint Stiffness				
Muscle Weakness				
Osteoporosis				
Broken Bones				
Joints Replaced				
NEUROLOGICAL		PRESENT	PAST	NO
Stroke				
Seizures				
Head Injury				
Brain Aneurysm				
Numbness				
Severe Headaches				
Pinched Nerves				
Parkinson's Disease				
Carpal Tunnel				
Spinning/Balance				
ENDOCRINE		PRESENT	PAST	NO
Thyroid Disease				
Diabetes				
Hair Loss				
Menopausal				
Menstrual Problems				
PSYCHIATRIC		PRESENT	PAST	NO
Depression				

Anxiety Disorder				
Unusual Stress				
CONSTITUTIONAL		PRESENT	PAST	NO
Weight Loss/Gain				
Energy Level Problem				
Difficulty Sleeping				