Welcome to
KOCH CHIROPRACTIC

Name _____ **Date** _____

Address _____ **City / State** _____ **Zip** _____

Phone #'s - Home _____ **Work** _____ **Cell** _____

Date of Birth _____ **Email** _____

Married? Y / N **Spouse's name/date of birth** _____ **#of Children** _____

Employer_____ **Occupation** _____

Who referred you to our office? _____

Do you have health insurance? YES / NO (*please provide copies of all insurance cards)

Who is responsible for payment of your bill? □**Self** □**Other:**_____

Is this an injury due to an <u>Auto accident</u>? YES / NO **Date of accident:** _____
Is this an injury due to a <u>Work injury</u>? YES / NO **Date of injury:** _____

Please answer the following questions and ☑ check all appropriate boxes.

1.Reason for this appointment (describe your problem.) _____
_____

2.Pain description: □sharp □dull □ache □burning □throbbing □tingling □numb □radiating □stiff

3.How frequently is it bothering you? □constantly □daily □weekly □monthly □_____

4.When did this problem start?_____

5.Since it started, is your problem: □getting better □about the same □getting worse

6.Have you ever had a similar problem in the past? □Yes □No If yes, when?_____
Explain_____

7.What do you think caused this problem? □? don't know □old injury □lifting injury □fall
□stress □car accident □work injury □exercise □chronic problem
Explain_____

8.Rate the severity of your pain at its worst: (circle #) mild 1 2 3 4 5 6 7 8 9 10 severe

9.What makes your problem feel <u>worse</u>? □standing □sitting □walking □ice □heat □stress
□lying down □lifting □bending □cough/sneeze □_____

10.What makes your problem feel <u>better</u>? □standing □sitting □walking □ice □heat
□lying down □activity □stretching □rest □_____

11.Does this condition adversely affect your: (☑check all that apply)

□ job attendance □ relationships □ sleep □ moods □ hobbies □ well-being
□ job performance □ concentration □ activities □ _____

12.What have you tried to solve this problem? □pain pills □anti-inflamm. □muscle relaxers □ice/heat □cortisone shot □surgery □massage □physical therapy □stretching □exercise □chiropractic □other _____

Did anything help? _____

13.List any past injuries you have had: □lifting injuries □falls □car accidents □broken bones

Explain_____

14. Do you currently have, or have you ever had <u>any problems with</u>: (☑check all that apply)

□headaches	□hip	□neck	□fatigue	□heart / blood pressure
□dizziness	□buttocks	□upper back	□sleep	□lung / asthma
□eyes	□leg	□mid back	□thyroid	□liver
□ears/hearing	□sciatic	□low back	□anxiety	□gall bladder
□sinus	□knee	□spinal discs	□depression	□stomach / ulcers
□allergies	□ankle / foot	□ribs	□stress	□pancreas /diabetes
□skin / rash	□shoulder	□stiffness	□tension	□kidney
□infections	□arm	□weak muscles	□weight	□digestion / heartburn
□colds / flu	□elbow	□muscle spasm	□fibromyalgia	□intestines / colon
□jaw (TMJ)	□wrist / hand	□joint arthritis	□cancer	□reproductive
□osteoporosis	□carpal tunnel	□numbness	□surgery	□bladder

□other_____

Explain:_____

15.Have you seen a medical doctor for these, or any other conditions?_____

_____

16.Do you take any medications? _____

17.Do you take nutritional supplements? □Yes □No **_____**

18.Do you Exercise regularly? □Yes □No **_____**

19.Rate your overall "life-stress" level: (circle #) No Stress 1 2 3 4 5 6 7 8 9 10 Overwhelming

20.How would you rate your overall health? □Excellent □Good □Fair □Poor

21.Have you ever been to a chiropractor? □Yes □No **Dr.'s Name_____**

When and what for? _____

22.What goals do you hope to achieve with Chiropractic?

□Relieve Pain □Correct the cause of the pain □Better alignment □Better movement
□Less muscle tension □Prevent future problems □Better overall health / Wellness

SIGNATURE_____ DATE_____