**Koelling Family Chiropractic** • 621 Commons Drive • Fulton, MO 65251 • phone 573.642.2273 • fax 573.642.1900

Name:_____Date:_____Account #:_____

Address:_____City_____State_____Zip_____

Phone:_____Birth Date:_____Social Security Number:_____

Spouse:_____Email address:_____

Children & Ages:_____

Occupation/ Employer:_____Phone:_____

Spouse Occupation/ Employer:_____Phone:_____

Other Emergency Contact:_____Phone:_____

How did you hear about our office? (and/ or who referred you):_____

Which Chiropractors (& dates) have you seen before?_____

Who is your family Medical Doctor; last visit:_____

## CURRENT PROBLEM

Please let us know what brings you to our office.

Please list the problem you are experiencing:_____

**WHEN** and **HOW** did the problem start?_____

Who have you seen, prior, for this problem? **CHIROPRACTOR** (D.C.) **M.D.** **OTHER** _____

Please list names and dates:_____

What else have you tried to help with this problem?_____

## PERSONAL HISTORY

We need to know all the facts about your health before we accept your case.
*Please mark the appropriate answers and provide the requested information.* **This is a Confidential Health Report.**

yes/ no **Traumatic Birth:** (use of forceps, vacuum extraction, cesarean, etc)_____

yes/ no **Car Accidents**: _____

yes/ no **Work Injuries**: _____

yes/ no **Sport Injuries:** (including Extreme Sports)_____

yes/ no **Other Accidents or Falls:**_____

yes/ no **Therapies:** _____

yes/ no **Surgeries**: _____

yes/ no **Vaccinations:** (any fevers or sickness following)_____

***(Please indicate how much per day or week.)***

yes/ no **ALCOHOL** _____

yes/ no **COFFEE** _____

yes/ no **TOBACCO** _____

yes/ no **EXERCISE** _____

yes/ no **SOFT DRINKS** _____

yes/ no **NUTRASWEET (EQUAL)**_____

yes/ no **NUTRITIONAL SUPPLEMENTS**_____

**What types of foods do you regularly eat?**_____

**Have you had extra stress in your life recently?**_____

**Please list any Drugs you are taking (including antibiotics, prescription, over the counter)**:_____

_____

***Please complete the other side***

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

OCCASIONAL FREQUENT

**GENERAL**
- ❑ ❑ Allergies (Air / Food)
- ❑ ❑ Blood sugar (high / low)
- ❑ ❑ Cholesterol (high / low)
- ❑ ❑ Convulsions / Seizures
- ❑ ❑ Dizziness or Fainting
- ❑ ❑ Energy Loss / Fatigue
- ❑ ❑ Headache / Migraine
- ❑ ❑ Memory Loss
- ❑ ❑ Neuralgia / Neuritis
- ❑ ❑ Nervousness
- ❑ ❑ Numbness
- ❑ ❑ Thyroid (high / low)

**MUSCLE & JOINT**
- ❑ ❑ Arthritis
- ❑ ❑ Bursitis
- ❑ ❑ Foot Problems
- ❑ ❑ Low back pain
- ❑ ❑ Neck pain / stiffness
- ❑ ❑ Pain between shoulders
- ❑ ❑ Sciatica
- ❑ ❑ Swollen Joints

Problems with:
- ❑ ❑ TMJ (jaw)
- ❑ ❑ Shoulders
- ❑ ❑ Arms
- ❑ ❑ Elbows
- ❑ ❑ Hands/ Wrists
- ❑ ❑ Hips
- ❑ ❑ Legs
- ❑ ❑ Knees
- ❑ ❑ Feet / Ankles

**GASTRO-INTESTINAL**
- ❑ ❑ Colon Problems
- ❑ ❑ Constipation
- ❑ ❑ Diarrhea
- ❑ ❑ Difficult digestion
- ❑ ❑ Distension of abdomen
- ❑ ❑ Gall bladder problems
- ❑ ❑ Heartburn / Reflux
- ❑ ❑ Hemorrhoids
- ❑ ❑ Liver problems
- ❑ ❑ Nausea
- ❑ ❑ Stomach pain

**EYES, EARS, NOSE, THROAT**
- ❑ ❑ Colds
- ❑ ❑ Deafness/ Hearing Loss
- ❑ ❑ Earache
- ❑ ❑ Ear discharge
- ❑ ❑ Ear infection
- ❑ ❑ Ear noises
- ❑ ❑ Eye pain
- ❑ ❑ Loss of taste
- ❑ ❑ Loss of speech
- ❑ ❑ Nasal obstruction
- ❑ ❑ Nosebleeds
- ❑ ❑ Ringing in ears
- ❑ ❑ Sinus infection
- ❑ ❑ Vision changes

**CARDIO-VASCULAR**
- ❑ ❑ Hardening of arteries
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Pain over heart
- ❑ ❑ Poor circulation
- ❑ ❑ Rapid heart beat
- ❑ ❑ Slow heart beat
- ❑ ❑ Swelling of ankles

**RESPIRATORY**
- ❑ ❑ Asthma
- ❑ ❑ Chest pain
- ❑ ❑ Chronic cough
- ❑ ❑ Difficult breathing
- ❑ ❑ Spitting up blood
- ❑ ❑ Spitting up phlegm
- ❑ ❑ Wheezing

**SKIN**
- ❑ ❑ Acne
- ❑ ❑ Bruise easily
- ❑ ❑ Dryness
- ❑ ❑ Skin eruptions (rash)
- ❑ ❑ Varicose veins

**GENITO-URINARY**
- ❑ ❑ Bed-wetting
- ❑ ❑ Blood in urine
- ❑ ❑ Frequent urination
- ❑ ❑ Loss of kidney control
- ❑ ❑ Kidney infection / stones
- ❑ ❑ Painful urination
- ❑ ❑ Prostate trouble
- ❑ ❑ Pus in urine
- ❑ ❑ Urinary Tract Infection

**FOR WOMEN ONLY**
- ❑ ❑ Cramps or backache
- ❑ ❑ Excessive menstrual flow
- ❑ ❑ Hot flashes
- ❑ ❑ Irregular cycle
- ❑ ❑ Lumps in breast
- ❑ ❑ Menopausal symptoms
- ❑ ❑ Painful menstruation
- ❑ ❑ Vaginal discharge

**Are you Pregnant YES NO**

Due Date_____

Date of last period_____

**Previous miscarriages YES NO**

**DATE OF LAST: (approximately)**

_____Physical Examination

_____Blood Test

_____Urine Test

_____Spinal x-ray

_____Chest x-ray

_____Dental x-ray

**HAVE YOU EVER:** **DATE**
- ❑ Been knocked unconscious?_____
- ❑ Used a crutch, or other support?_____
- ❑ Been treated for a spine or nerve disorder?_____
- ❑ Had a fractured bone?_____
- ❑ Been hospitalized for other than surgery?_____
- ❑ Had a nutritional analysis?_____

**<u>Check</u> the following conditions you have or have had. <u>Circle</u> items that are common to other family members.**

NOW IN PAST

- ❑ ❑ AIDS / HIV
- ❑ ❑ Alcoholism
- ❑ ❑ Anemia
- ❑ ❑ Appendicitis
- ❑ ❑ Arteriosclerosis
- ❑ ❑ Cancer
- ❑ ❑ Chicken Pox
- ❑ ❑ Diabetes
- ❑ ❑ Depression
- ❑ ❑ Eczema
- ❑ ❑ Emphysema
- ❑ ❑ Epilepsy
- ❑ ❑ Fibromyalgia
- ❑ ❑ Foot Problems
- ❑ ❑ Goiter
- ❑ ❑ Gout
- ❑ ❑ Heart Disease
- ❑ ❑ Lupus
- ❑ ❑ Measles
- ❑ ❑ Multiple Sclerosis
- ❑ ❑ Mumps
- ❑ ❑ Pacemaker
- ❑ ❑ Pneumonia
- ❑ ❑ Polio
- ❑ ❑ Rheumatic Fever
- ❑ ❑ Scarlet Fever
- ❑ ❑ Stroke
- ❑ ❑ Tuberculosis
- ❑ ❑ Typhoid Fever
- ❑ ❑ Ulcers
- ❑ ❑ Venereal Disease
- ❑ Other_____

I acknowledge all my responses are accurate to the best of my knowledge._____Date:_____

**(please sign name — if patient is a minor, parent or guardian please sign)**

**Koelling Family Chiropractic** • 621 Commons Drive • Fulton, MO 65251 • phone 573.642.2273 • fax 573.642.1900

Name_____Account #_____

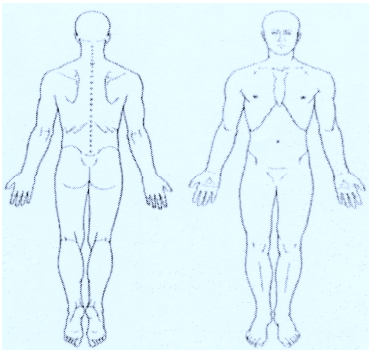
1- Please describe the **condition(s)** that brought you to this office, beginning with your highest **priority** (A) to lowest (C). If you have no health concerns please write "wellness checkup."

A_____

B_____

C_____

**Please mark where you have your symptoms.**



2- Circle the severity of your problem 1 = No Pain 10 = Very Severe

| | | |
|---|---|---|
| Neck | right - left - both | 1 2 3 4 5 6 7 8 9 10 |
| Mid Back | right - left - both | 1 2 3 4 5 6 7 8 9 10 |
| Low Back | right - left - both | 1 2 3 4 5 6 7 8 9 10 |
| Arms | right - left - both | 1 2 3 4 5 6 7 8 9 10 |
| Legs | right - left - both | 1 2 3 4 5 6 7 8 9 10 |
| Other_____ | | 1 2 3 4 5 6 7 8 9 10 |

3- **Circle** the **sensations** you are experiencing. Sharp Pain - Burning - Dull Pain - Tingling - Throbbing - Cramping - Numbness - Stiffness - Aching - Swelling - Shooting - Stabbing

4- How **often** do you experience your problem? Constantly - 75% time - 50% time - Less than 25%

5- What **date** & **how** did your problem begin?_____

6- Did this result from an **injury** or accident at: home - work - car accident - other - no injury

7- Has your **condition**: improved - gotten worse - stayed the same

8- What makes your problem **worse**: walking - standing - sitting - movement - twisting - lifting - sneezing – coughing - bending - lying – other:_____

9- What makes your problem **better**? _____

10- Have you had this **before**? No - Yes when:_____ Treated by whom?_____

11- **What** treatment did you receive? _____ Date last treated:_____

12- **Results** of previous treatment: good - poor - comments:_____

13- What is this problem **interfering** with: work - sleep - daily routine - recreation - other:_____

14- What do you believe is **wrong** with you?_____

15- Name of last **Chiropractor** who treated you:_____

Date you were last seen:_____

16- Name of last **MD or DO** who treated you:_____

Date you were last seen:_____

17- **Females:** Is there any possibility that you are **pregnant**? No - Yes Date of last cycle:_____

18- **Other** health related **information** we should be aware of:

Signature_____ Today's Date:_____

I certify that the above information is accurate to the best of my knowledge.

Koelling Family Chiropractic – 621 Commons Drive – Fulton, MO 65251 – fax (573) 642-1900 – ph (573) 642-2273

# - CONSENT FOR TREATMENT -

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I understand and agree that all x-rays and medical records remain the property of this clinic and will be maintained in this clinic up to seven years. If coordination of care is needed, **we will gladly send them to the requesting doctor for you**. If you lapse in your care for an extended period of time, or have new accidents or changes in your health status, additional examinations may be required to update your history and health status before further care can continue. It will be determined by the doctor at that time. The **primary practice objective** of this office is to help restore **HEALTH** by reducing **SUBLUXATIONS** with chiropractic **ADJUSTMENTS. We do not diagnose or treat any disease or condition other than subluxations (spinal and extremities.)** If, however, during the course of chiropractic care we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

# - RELEASE OF INFORMATION -

We want you to know how your **Patient Health Information** is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. If there is anyone you do not want to receive your medical records, please inform our office.
3. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this clinic to assure that your records are not easily available to those who do not need them.

# - FEMALE PATIENTS ONLY-

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected at this time. The approximate date of my last menstrual period was _____

# - ASSIGNMENT OF BENEFITS -

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to **Koelling Family Chiropractic, PC** as payment for professional services rendered.

# - BILLING INFORMATION -

**Your insurance policy is a contract between you and your carrier**. Many policies reimburse for at least some chiropractic care. But coverage varies from policy to policy, and constantly changes. You understand and agree that you are responsible for all charges not paid by your insurance company. Our goal is to help you get well and stay well. We ask you pay at the time of service, **including Medicare patients. We will file your visit to Medicare and Medicare will reimburse you. Our fees are already reduced by Medicare and we do not accept assignment from them. We do not expect them to be sending payment to our office.**

***Your signature indicates that you accept financial responsibility for your care, and you are instructing this office to deliver the care that, in our judgment, can best help you in the restoration of your health.***

**Print Your Name**_____

**Signature** _____**Date**_____