

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 ...

Is it okay to call you at work?

- Yes No

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> 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:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |

Surgeries:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |

Allergies:

- | | | | |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasional | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | | |

Substance Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | | |

Male Children:

- Under 6 years
- Under 10 years
- Under 19 years

Female Children:

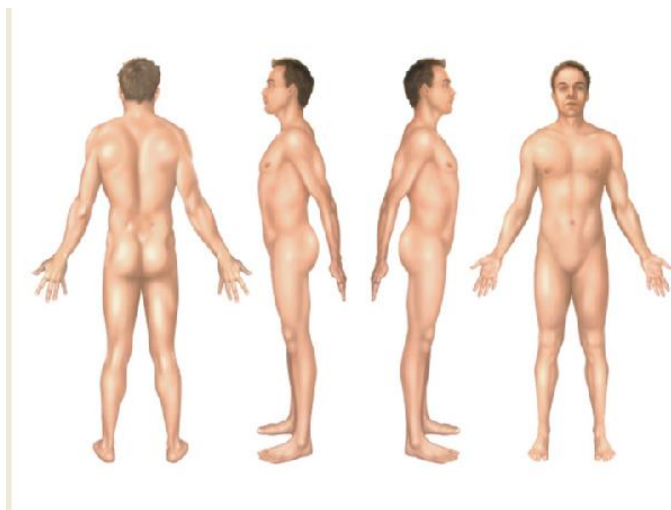
- Under 6 years
- Under 10 years
- Under 19 years

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
 Homemaker

White Collar/Secretarial
 Full-time Student

Tradesperson
 Retired

Laborer
 Other

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

Full-time
 Off work

Part-time
 Other

Self-employed

Unemployed

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

<u>CARDIOVASCULAR</u>		<u>PRESENT</u>	<u>PAST</u>	<u>NO</u>
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				
<u>GENITOURINARY</u>		<u>PRESENT</u>	<u>PAST</u>	<u>NO</u>
Kidney Disease				
Lower Side Pain				
Burning Urination				
Frequent Urination				
Blood in Urine				
Kidney Stone				
<u>HEMATOLOGIC/ LYMPHATIC</u>		<u>PRESENT</u>	<u>PAST</u>	<u>NO</u>
Hepatitis				
Blood Clots				

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

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

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

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