Kluver Chiropractic & Wellness

PATIENT INTRODUCTION

Personal Information:

Your Name:

____

First Middle Initial Last

Your Address:

____

____

Telephone Number: ____________ ______________ ______________

Home Business Cell

E-mail Address:

____

Birth Date: ________________

Marital Status: ______________

Occupation: ________________

Employer: _________________

Previous Chiropractor: ________________________ City:

____

Reason for leaving:

____

____

____

Present MD: ______________________________________ City: ________________________

Referred to our Center by: ____
____
____

Please understand that any fees incurred at Kluver Chiropractic that will not be paid by insurance/third party, will be the patient's personal responsibility.

I give my consent to have the doctor take any x-ray he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: ______________________________ DATE: ________________________

(Signature of Parent/Guardian required if patient under age of 18)

THANK YOU!

Kluver Chiropractic & Wellness

PATIENT CONSULTATION

Your Main Complaint:
____

Any Other Complaints:
____

How long have you suffered with this problem?
____

What have you tried to do to get rid of this problem that **DID NOT** work?
____
____

Have you become discouraged about handling this problem?
____

When your problem is at its worst, how does it make you feel?
____

How does this problem interfere with the following areas of your life?

Work: _________________________________

Family: ______________________________

Hobbies: _____________________________

Life: _________________________________

Does handling this problem cause stress for you?
____

What do you do that makes this problem worse?
____

How much older does it make you feel?
____

On a scale of 1 to 10 being the highest, rate your commitment in helping us solve this problem: ______________________

What gives you some temporary relief?
____

What is the pattern of this problem?
Constant_____, Intermittent________, Occasional_________,
Cyclic_______

What is the effect it has on your body functions?
____

How did it start?
____

Are you on any type of medication? If yes, please list all:
____
____

Could your problem have been caused by any injury at work?
____

If yes, please give us the details:
____

Have you been involved in an auto accident?
____

Date of accident and any difficulties from this:
____

Do you have any children?
____

Do they have any health problems that you are aware of?
____
____

Is there any information that you would like us to know?
____
____

SIGNATURE:____
DATE:_____________

For Women Only

Date of your last menstrual period:
____

Are you using any means of contraception?
____

Do you experience severe cramping with your menstrual period?
____

Do you suffer from PMS?
____

THANK YOU!