

Confidential Case History

WELCOME TO KALKSTEIN FAMILY CHIROPRACTIC

Date _____ Last Name _____ First Name _____

Birth Date (M/D/Y) _____ Age _____ Female _____ Male _____ Occupation _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Email Address _____

Name of Spouse _____ Names/ages of children _____

Name and number of Emergency Contact _____

How did you find out about our office? _____

If you were referred to our office, whom may we thank? _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. The case history will uncover layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates symptoms. Then begins Reconstructive Care which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

DANGEROUS BODY SIGNALS INDICATING UNDERLYING DYSFUNCTION

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins/Needles in Arms/Leg |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stress | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Overall Joint Pain/Stiffness |
| <input type="checkbox"/> Difficulty Walking/Sitting | <input type="checkbox"/> Difficulty Driving | <input type="checkbox"/> Difficulty Working | <input type="checkbox"/> Difficulty Lifting/Bending |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Coordination |
| <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Moody/Irritable | <input type="checkbox"/> Lack of Concentration |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Menopausal Difficulties |
| <input type="checkbox"/> Fertility Dysfunction | <input type="checkbox"/> Prostate Dysfunction | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Menstrual Difficulties |

Are any of your friends or family suffering from any of these dangerous body signals? Yes No

If so, who? _____

Please list ALL known previous injuries

Description	Date(s)
Accidents/Falls _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Hobbies/Sports Injuries _____	_____
Surgeries _____	_____

REASON FOR YOUR VISIT

Is this a work related injury? Yes (**See front Desk**) No

Is this a motor vehicle accident case? Yes (**See front Desk**) No

What brought you into this office/What is your main concern? _____

When did the symptom of this underlying dysfunction first appear? _____

Have you had this problem before? Yes No

Is there a specific event that caused your current concern? (Describe) _____

Are your symptoms: Constant Intermittent Daily

Do your symptoms radiate? If so, where? _____

What is the intensity of your pain/symptoms on a scale of 1 – 10? (10 being the worse) _____

Describe the character of your pain/symptoms (dull, achy, sharp, throbbing, numbness, etc) _____

What aggravates your symptoms? _____ What relieves your symptoms? _____

Anything associated with your pain/symptoms? (Wake you up at night, problem urinating, fever etc) _____

Does this problem interfere with: Work Sleep Daily Routine Moods

Are your problems: getting worse getting better staying the same

Other Doctors/Therapists that have treated this condition _____

Have you ever been diagnosed with a medical condition? Yes No

Are you now using or have you ever used prescription drugs? Yes No

Describe **PAST/CURRENT** _____

Insurance

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Co. _____ Group # _____

Is patient covered by additional insurance? Yes No Subscriber's Name _____

Birthdate _____ SS# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and

assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative Date Relationship to Patient