WELCOME FORM

KAISER CHIROPRACTIC, S.C.

This information is considered strictly **confidential**. We need this information because we care for your well-being. In order for us to understand your condition properly, please be as neat and accurate as possible when completing this form. Please use a black OR blue pen. Thank you.

PATIENT INFORMATION:

Name____ Date____________________

Name you prefer______________________________ Date of Birth______/______/__________ Age__________

Address____ City/State/Zip_____________________________

Home phone ☐ (__)____________________ Cell# ☐ (__)____________________Social Security #______________________

(Please check which phone# is the best to reach you at)

E-mail__________________________________ Current M.D.__________________________________

Occupation/even if retired________________________ Employer____________________ Phone(_____)________________

Ht.___'_____" Wt._____ Gender:☐M ☐F Marital Status:☐Single ☐Married ☐Widowed ☐Divorced No. of children_____

Spouse's name________________________ Spouse's Employer_____________________ Phone (______)________________

Emergency Contact (Required) _______________________________________ Phone (______)__________________

Previous Chiropractor____________________________________ Who Referred you to us?__________________________

FAMILY HISTORY: (☐ Please check this box and skip this section if you are adopted.)

Please indicate "**M**" for *Mother's side* and "**F**" for Father's *side* (Example: Your father's brother would be F Uncle/Lung Cancer)

Heart Disease ☐Yes ☐No If yes, who?______________________ Cancer ☐Yes ☐No If yes, who?____________________

Stroke ☐Yes ☐No If yes, who?______________________ Diabetes ☐Yes ☐No If yes, who?____________________

High Blood Pressure ☐Yes ☐No If yes, who?____________________ Kidney Disease ☐Yes ☐No If yes, who?____________________

Muscle/Bone/Nerve Disease ☐Yes ☐No If yes, who?______________________ Other________________________________

TRAUMAS, SURGERIES, HOSPITALIZATION: *Have you ever:*

Been Hospitalized? ☐Yes ☐No If yes, please explain____

____

Been in an auto accident? ☐Yes ☐No If yes, please explain____

____

Had surgery? ☐Yes ☐No If yes, please explain____

____

DEMOGRAPHIC QUESTIONS: (Required for Health Records)

Language: ☐ English ☐ Spanish ☐ Other, please specify: ________________________

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Native ☐ Other Race ☐ White

Ethnicity: ☐ Unspecified ☐ Hispanic or Latino ☐ Not Hispanic or Latino

The items listed below may relate to your current condition. Please check the appropriate box in each section:

"N" for Never: if you have never had this before, **"P" for Past:** if you have ever had this before, or **"C" for Current:** if you currently have this.

GENERAL:

N	P	C	
☐	☐	☐	Loss of Sleep
☐	☐	☐	Fatigue
☐	☐	☐	Nervousness
☐	☐	☐	Weight Loss/Gain
☐	☐	☐	Allergies
☐	☐	☐	Anemia
☐	☐	☐	Diabetes
☐	☐	☐	Cancer

Type of Cancer______________________

N	P	C	
☐	☐	☐	Thyroid Disease
☐	☐	☐	Alcoholism
☐	☐	☐	Drug Abuse

GASTROINTESTINAL:

N	P	C	
☐	☐	☐	Change of Appetite
☐	☐	☐	Poor Digestion
☐	☐	☐	Nausea
☐	☐	☐	Pain over Abdomen
☐	☐	☐	Ulcers
☐	☐	☐	Hernia
☐	☐	☐	Liver Problems
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Hemorrhoids
☐	☐	☐	Appendicitis

Date of Appendicitis____/____/______

GENITOURINARY:

N	P	C	
☐	☐	☐	Frequent Urination
☐	☐	☐	Kidney Disease
☐	☐	☐	Urinary Infection
☐	☐	☐	Inability to Control Urination
☐	☐	☐	Breast Lump or Pain

DIET:

☐ I eat fast food, candy, etc. more than 6 times/month.

☐ I occasionally eat fast food, candy, etc. 1-5 times/month.

☐ It is rare for me to eat fast food, candy, etc.

EARS, EYES, THROAT:

N	P	C	
☐	☐	☐	Pain in eyes
☐	☐	☐	Deafness/Difficulty hearing/Ear noises
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus Problems
☐	☐	☐	Tonsillectomy

Date of Tonsillectomy ___/___/_____

RESPIRATORY:

N	P	C	
☐	☐	☐	Difficulty breathing
☐	☐	☐	Chronic cough
☐	☐	☐	Asthma
☐	☐	☐	Pneumonia

Date of Pneumonia ____/_____/_____

N	P	C	
☐	☐	☐	Tuberculosis

CARDIOVASCULAR:

N	P	C	
☐	☐	☐	Irregular Heartbeat
☐	☐	☐	High Blood Pressure

Last BP Reading ______/______

N	P	C	
☐	☐	☐	Pain over Heart
☐	☐	☐	Ankle Swelling
☐	☐	☐	Varicose Veins
☐	☐	☐	Stroke

Date of Stroke_____/_____/_______

MUSCULOSKELETAL:

N	P	C	
☐	☐	☐	Neck stiffness/pain
☐	☐	☐	Low Back pain
☐	☐	☐	Swollen joints
☐	☐	☐	Muscle aches/soreness
☐	☐	☐	Spinal Curvature
☐	☐	☐	Arthritis

HABITS:

N	P	C	
☐	☐	☐	Smoking

Packs per day __________

N	P	C	
☐	☐	☐	Drinking Alcohol
☐	☐	☐	Recreational Drug use

WOMEN:

N	P	C	
☐	☐	☐	Painful Periods
☐	☐	☐	Excessive Flow
☐	☐	☐	Irregular Cycle
☐	☐	☐	Hot Flashes
☐	☐	☐	Birth Control

Type of birth control__________________

MEN:

N	P	C	
☐	☐	☐	Testicular Swelling/Pain
☐	☐	☐	Prostate Problems

SKIN:

N	P	C	
☐	☐	☐	Itching
☐	☐	☐	Bruise easily
☐	☐	☐	Change in Mole(s)
☐	☐	☐	Skin Cancer

Type of Skin Cancer __________________

NEUROLOGIC:

N	P	C	
☐	☐	☐	Weakness
☐	☐	☐	Tremors
☐	☐	☐	Headaches

Frequency of headaches ____wk____mth

N	P	C	
☐	☐	☐	Fainting
☐	☐	☐	Dizziness
☐	☐	☐	Epilepsy
☐	☐	☐	Numbness/Tingling
☐	☐	☐	Forgetfulness
☐	☐	☐	Depression

EXERCISE:

☐ None ☐ 1-3/weekly ☐ 4-6/weekly

COMMON SLEEPING POSITION:

Please check all that apply

☐ Back ☐ Stomach ☐ Side

Do you currently take any prescription medications for;

High Blood Pressure? ☐ Yes ☐ No High Cholesterol? ☐ Yes ☐ No Elevated Blood Sugar levels? ☐ Yes ☐ No

Please list all medications (**WITH DOSAGE & AMTS**) that you are taking and for what condition ______________________________________

____

____

Medication Allergies ____

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. Kaiser Chiropractic S.C. is pleased to accept your insurance assignment. However, it must be fully understood that you are fully responsible for any amount not paid by your insurance, regardless of their reason.
I understand that delinquent accounts accumulate at 12% interest annually.
I hereby give permission to Dr. Kaiser & Kaiser Chiropractic, S.C. to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition, regardless of what my insurance plan/policy may or may not cover.

Patient Signature ____ Date:________________________