# Welcome!

Dr. Elizabeth Kinneavy

Dr. Tanya Bruns

Thank you for choosing our office for your chiropractic care. We look forward to helping you.

## Front Street Chiropractic

Account #____________________

Patient Name ____________________________________________ Date ____________________

Address ______________________________ City ________________ State _____ Zip _________

What name do you prefer to be called? ____________________ DOB _____/_____/_______ Age ______

Cell Phone (______)__________________ Can we leave a detailed message on this phone? ❑ Yes ❑ No

Home Phone (______)__________________ Can we leave a detailed message on this phone? ❑ Yes ❑ No

Email _____________________________________

May our office to send you appointment reminders? ❑ Yes ❑ No (Our office only sends one reminder)

Would you prefer ❑ Text **or** ❑ Email If text, cell carrier ____________________ (ie: AT&T, Verizon)

Please note* A Missed Appointment fee may be added to your account for missing a scheduled appointment.

Marital Status ❑ Single ❑ Married ❑ Divorced Spouse's Name ______________________________

Do you have children? Please list how many & ages ________________________________________

Are you Currently employed? ❑ Yes ❑ No Student? ❑ Full-Time ❑ Part-Time

Employer name ______________________________ Job title ______________________________

Work Phone (______)__________________ Can we leave a detailed message on this phone? ❑ Yes ❑ No

Have you ever been treated by a chiropractor before? ❑ Yes ❑ No If so, Whom?___________________

Who can we thank for referring you to our office? ________________________________________

Emergency Contact _________________________________ Phone (______)__________________

Relation _____________________________________ Other phone (______)__________________

Who is your medical doctor? ___________________________ Phone (______)__________________

- We invite you to discuss any questions regarding our services with us. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

____________________________________________________ Date ____________________

Patient Signature

____________________________________________________ Date ____________________

Parent or Guardian Authorized Signature

Updated 05/2017

REASON FOR TODAY'S VISIT

Is the reason for your visit realated to ❑ Work ❑ Athletics ❑ Trauma ❑ Chronic ❑ Other

Please note * If this is an auto related incident we have different paperwork.

Explain what happened: ______________________________________________

______________________________________________

Describe the pain and its location: ______________________________________________

______________________________________________

When did this condition begin? ___/___/_____

On a scale of 0-10 (0=no pain, 10=extreme pain) pleasse rate your pain __________

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & Goes

Is this condition interfering with ❑ Work ❑ Daily Routine ❑ Sleep ❑ Exercise

If so, please explain ______________________________________________

______________________________________________

Do you have a prior history of similar complaints? ❑ Yes ❑ No

If yes, please list dates, prior treatment, restults, etc. ______________________________________________

______________________________________________

Have you ever been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? ______________________________________________

Please describe any additional complaints ______________________________________________

______________________________________________

Doctor's Notes

Location ______________________________________________

Qual & Char ______________________________________________

Onset ______________________________________________

Radiation ______________________________________________

Timing ______________________________________________

Alleviating ______________________________________________

Worse ______________________________________________

Other Tx ______________________________________________

## PAST MEDICAL HISTORY

Have you ever had and of the following diseases/medical conditions?

- ❑ Heart Attack/Stroke
- ❑ Congenital Heart Defect
- ❑ Alcohol/Drug Abuse
- ❑ HIV+/Aids
- ❑ Frequent Neck Pain
- ❑ High/Low Blood Pressure
- ❑ Severe/Freuent Headaches
- ❑ Fainting/Seizures/Epilepsy
- ❑ Heart Surgery/Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ Venereal Disease
- ❑ Shingles
- ❑ Emphysema/Glaucoma
- ❑ Psychiatric Problems
- ❑ Kidney Problems
- ❑ Sinus Problems
- ❑ Heart Murmur
- ❑ Arificial Valves
- ❑ Hepatitis
- ❑ Cancer
- ❑ Anemia
- ❑ Rheumatic Fever
- ❑ Ulcers/Colitis
- ❑ Diabetes/Tuberculosis
- ❑ Artificial Bones/Joints
- ❑ Arthritis
- ❑ Lower Back Problems
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Chemotherapy
- ❑ Difficulty Breathing
- ❑ Asthma

Please list any other serious medical conditions you may have or had: ______________________________

______________________________________________________________

Please list anything you may be allergic to: ______________________________

List previous surgeries & treatment with dates: ______________________________

______________________________________________________________

List any serious past accidents with dates: ______________________________

______________________________________________________________

## FAMILY HEALTH HISTORY (list relationship)

Cancer ____________ Diabetes ____________ Stroke ____________

Heart Disease ____________ High Blood Pressure ____________

Other ______________________________

Are you taking any of the following medications?

❑ Pain Killers ❑ Muscle Relaxants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Birth Control Pills

Please list any medication you are on and what they are for______________________________

______________________________________________________________

Are you taking any vitamins or suppliments? ❑ Yes ❑ No If so, please list: ____________

______________________________________________________________

## HABITS & ACTIVITY

Do you, or have you ever smoked tobacco? ❑ Yes ❑ No If yes, how many packs per day? ____________

Do you, or have you ever used alcohol? ❑ Yes ❑ No If yes, how much & what type? ____________

Do you drink caffeinated beverages? ❑ Yes ❑ No If yes, how much & what type? ____________

Do you exercise regularly? ❑ Yes ❑ No If yes, please list activity & intensity ____________

**For Women:** Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No Date of last menses ___/___/_____

What particular activities in your daily routine are you having difficulty with due to your present complaint(s)?

______________________________________________________________

Are there any other health concerns that we did not ask and you believe we should know about?

______________________________________________________________

Doctor's Notes

______________________________________________________________

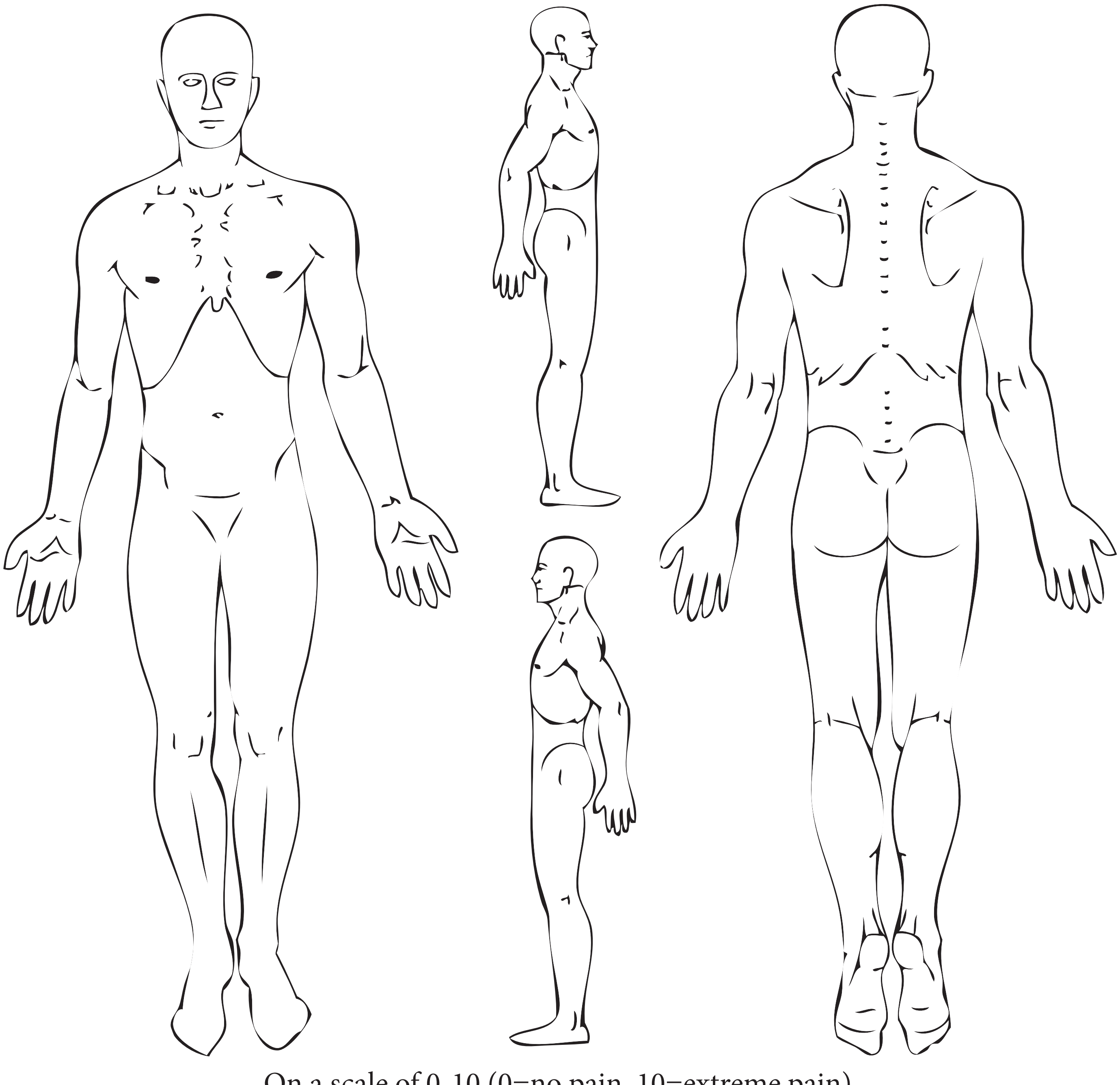
______________________________________________________________

______________________________________________________________

Patient Name ______________________________ Date ________________

Please circle the location on the figure below in the areas of you pain or discomfort.
Use the letters shown to represent the typle of sensation you are experiencing.

**D** = Dull **N** = Numbness **T** = Tingling (pins and needles)
**B** = Burning **S** = Stabbing/Cutting **C** = Cramping



On a scale of 0-10 (0=no pain, 10=extreme pain)

Rate the pain you have right **now:**

0 1 2 3 4 5 6 7 8 9 10

Rate the pain at its **best** in the past week:

0 1 2 3 4 5 6 7 8 9 10

Rate your **average** pain in the past week:

0 1 2 3 4 5 6 7 8 9 10

Rate your **worst** pain in the past week:

0 1 2 3 4 5 6 7 8 9 10