CONFIDENTIAL HEALTH HISTORY: KRUSE CHIROPRACTIC CLINIC

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Personal:

Name: _____ (Name title, first name, last name) Sex: _____ (M or F) Marital Status: _____ (M S D W) Date of Birth: _____ (Month Day Year)

Home Phone: (____)_____ Cell Phone: (____)_____ E-mail: _____

Address: _____ (Include street type such as ST. , Ave. , etc.) City: _____ State: _____ Zip Code: _____

Who referred you to our office: _____ Your Occupation: _____ (If student, unemployed, homemaker, etc please indicate)

Business Phone: (_____)_____ Company Name: _____

Spouse's First Name: _____ Spouse's Employer _____

Who to contact in case of an emergency: _____ Phone: _____

Primary Care Physician's Name: _____

I am seeking care in this office for: (Check one of following)

- ☐ Temporary Relief of Symptoms
- ☐ Relief of Symptoms and Stabilization of the Problem (Initial Intensive Care)
- ☐ Relief, Stabilization and Correction of the Problem (Spinal Reconstructive Care)
- ☐ No Symptoms, Interested in Maintaining Optimum Health (Wellness Care)

Please place a check (√) by any of the listed below that you are experiencing: (Other conditions not listed can be written below.)

MUSCULO-SKELETAL SYSTEM:

___ Low back Problems
___ Pain Between Shoulders
___ Neck Problems
___ Arm Problems
___ Leg Problems
___ Swollen/ Painful Joints
___ Stiff Joints
___ Sore Muscles
___ Weak Muscles
___ Walking Problems

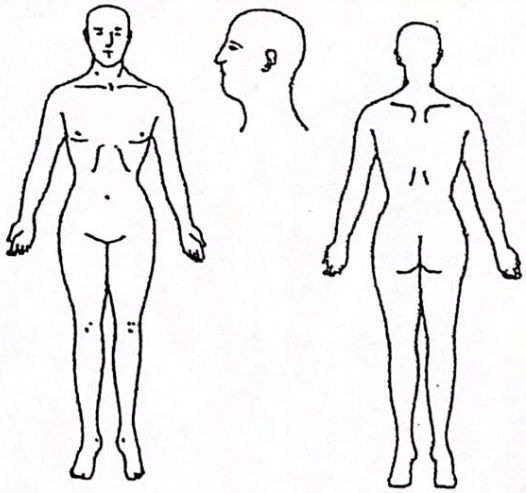
NERVOUS SYSTEM:

___ Numbness
___ Loss of Feeling
___ Paralysis
___ Dizziness/Fainting
___ Confusion
___ Headaches
___ Muscle Jerking
___ Convulsions
___ Forgetfulness
___ Depression

SPINAL CORD PRESSURE SYMPTOM:

___ Headaches
___ Dizziness
___ Blurred Vision
___ Loss of Concentration
___ Depression
___ Nervousness
___ Fatigue
___ Difficulty in Sleeping
___ Irritability

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURE BELOW:



OTHER CONDITIONS:

_____
_____
_____
_____
_____
_____

I UNDERSTAND THAT ALL TREATMENTS, X-RAYS AND LABORATORY EXAMINATIONS ARE TO BE PAID FOR AS THEY ARE RECEIVED OR DEFINITE FINANCIAL ARRANGEMENTS MADE IN ADVANCE.

Check Box to receive quarterly Email Newsletters. ☐
May we have permission to include your name in our quarterly Newsletter (in our New Patient Welcome List) and our "Patients in the News" bulletin board in the office? Please circle one: YES or NO

Patient (or Parent/Guardian) Signature: _____ Date: _____