Klinginsmith Family Chiropractic, P.C.

John F. Klinginsmith, D.C.
Chiropractor

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Patient Data

Insurance _____ **Date** _____

Title *(Check one)* ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **Dr.** ☐ **Other** _____

First Name _____ **Middle Initial** _____ **Last Name** _____

I prefer to be called by *(nickname)* _____

Date of Birth _____ / _____ / _____ **Age**_____ **Sex:** ☐ **Male** ☐ **Female**

Social Security Number _____ - _____ - _____ **Email** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Cell Phone (_____) _____ - _____ **Home Phone** (_____) _____ - _____

Employment Status: ☐ **Employed** ☐ **Unemployed** ☐ **FT Student** ☐ **PT Student** ☐ **Other**_____

Occupation if Employed _____

Emergency Contact _____

Relationship to Patient _____

Emergency contact phone number (_____) _____ - _____

How did you hear about our office? _____

Have you ever had chiropractic care before? ☐ **Yes** ☐ **No**

For what problem? _____

Were the results satisfactory? ☐ **Yes** ☐ **No** ☐ **N/A**

Have you seen anyone else for this problem? _____

Office Hours:
Mon. & Thurs. 8:00 AM-5:00 PM | Tues.8:00 AM - 2:00 PM | Wed. & Fri. 8:00 AM - 12:00 PM

Patient Name _____ **Date** _____

Are you pregnant? ☐ **Yes** ☐ **No** ☐ **N/A**

Major complaints - please be specific in describing what brings you in today: _____

_____

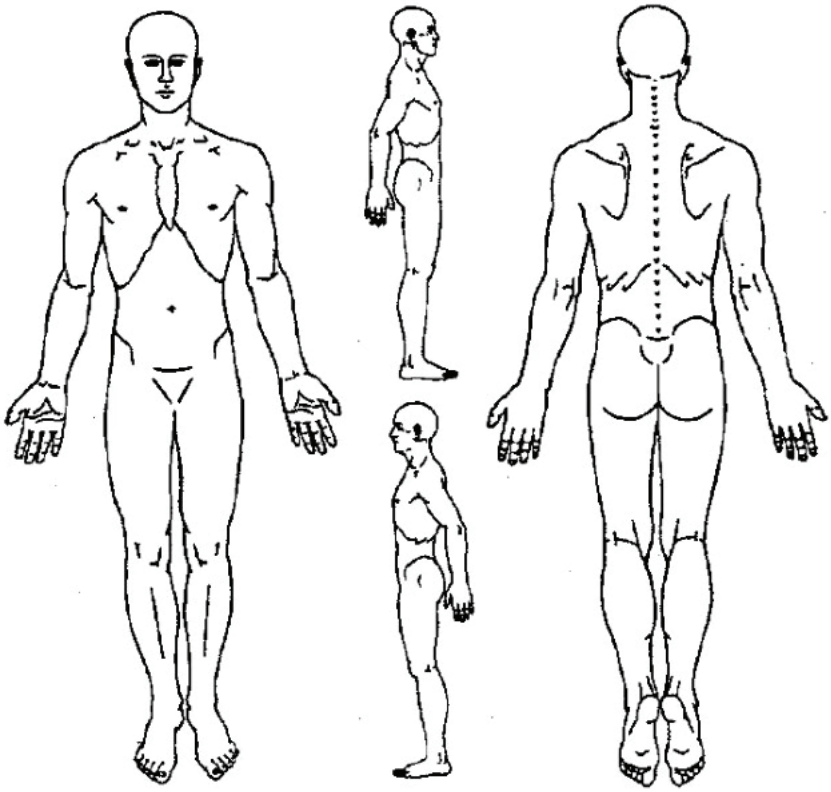
When did you first notice this problem/pain? _____

How do you believe this problem/pain began? _____

During the course of the day how often do you experience your symptoms?

☐ **Intermittently 0 - 25%** ☐ **Occasionally 26 - 50%** ☐ **Frequently 51 - 75%** ☐ **Constantly 76 - 100%**

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating, from 0-10, how much pain are you experiencing?
(0 = no pain and 10 = the worst pain imaginable)

Please circle the pain level over the last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Please circle the pain average level over the last week: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

Are your symptoms a result of: ☐ **Motor Vehicle Accident** ☐ **Work related accident** ☐ **Other**_____

How much have your symptoms changed? ☐ **Getting Better** ☐ **Getting Worse** ☐ **Not Changing**

In general, my overall health is..... ☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**