

# Kauai Chiropractic and Wellness Center

## Patient Information & History

Date: \_\_\_\_\_

**1 PATIENT INFORMATION**

Name: \_\_\_\_\_  
(First) (Initial) (Last) (Name called by)

Address: \_\_\_\_\_  
 \_\_\_\_\_

Birthday: \_\_\_\_\_ Age: \_\_\_\_  Male  Female

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Parents Name(if a minor): \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Spouse's Name: \_\_\_\_\_

# of Children: \_\_\_\_ Name(s) \_\_\_\_\_

**2 INSURANCE**

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance company \_\_\_\_\_

Insurance ID number \_\_\_\_\_

Group / Claim number \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Insurance company \_\_\_\_\_

Subscriber # and name \_\_\_\_\_

Birthdate \_\_\_\_\_ Group # \_\_\_\_\_

Please present insurance card(s) so we can put a copy in your file.

**3 ACCIDENT INFORMATION**

Is your condition due to an accident?  No  Yes Date: \_\_\_\_\_

Type of accident?  Automobile  Work  Home  Other

To whom have you reported the accident?

Insurance  Worker's Comp  Employer  Other \_\_\_\_\_

Attorney Name (If applicable) \_\_\_\_\_

**4 CONTACT INFORMATION**

Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Email \_\_\_\_\_

Best way to reach you  Home  Cell  Work  Email

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

**5 PATIENT CONDITION**

What is your major symptom/problem? \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_

Is your condition getting progressively worse? Yes  No

Is this problem:  constant  comes and goes

How does it Feel?  Burning  Sharp  Shooting  Dull  Aching  Stiff

Tingling  Throbbing  Swelling  Other \_\_\_\_\_

Circle below the severity of your pain on a scale of 0 to 10:  
 (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

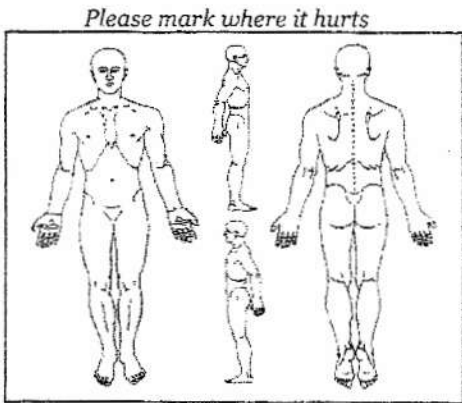
What makes your condition better? \_\_\_\_\_

What makes your condition worse? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities/movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying down  Driving  Reading  Getting Up



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## HEALTH HISTORY

What other treatments have you had for this condition?

- Chiropractic  Orthopedic  Neurologist  Physical Therapy  Medication  Surgery

Name of other doctors who have treated you for this condition \_\_\_\_\_

Describe the other doctor's treatment for your condition \_\_\_\_\_

Previous Chiropractic care?  No  Yes Date \_\_\_\_\_  Local  Out of state \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ MRI \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Dental x-ray \_\_\_\_\_ CT- Scan \_\_\_\_\_

List any Medications you are taking \_\_\_\_\_

Vitamins / Herbs / Minerals \_\_\_\_\_

**Females:** Are you Pregnant  Yes  No Beginning of last menstrual cycle \_\_\_\_\_

Check any of the following conditions you have had:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Ear ringing          | <input type="checkbox"/> Neck pain            |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> -Anxiety/Depression | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Poor circulation     |
| <input type="checkbox"/> Arm/shoulder pain   | <input type="checkbox"/> Headaches - Migraine | <input type="checkbox"/> Prostate problems    |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Sciatica             |
| <input type="checkbox"/> Bladder problems    | <input type="checkbox"/> Herniated disk       | <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Sinus infection      |
| <input type="checkbox"/> Chronic fatigue     | <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Deafness            | <input type="checkbox"/> Irregular cycle      | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney problems      | <input type="checkbox"/> TMJ                  |
| <input type="checkbox"/> Digestion problems  | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Earache             | <input type="checkbox"/> Low back pain        | <input type="checkbox"/> Vertigo/Dizziness    |

### STRESSORS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/ Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

### EXERCISE

- None
- Moderate
- Daily
- Heavy

Have you had any:

Description

Date

Automobile accidents \_\_\_\_\_

Surgeries \_\_\_\_\_

Broken bones \_\_\_\_\_

Falls/Head injuries \_\_\_\_\_

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## AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize KAUAI CHIROPRACTIC AND WELLNESS CENTER to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Signature

Date

Parent (if patient is a minor)