

KRAPF CHIROPRACTIC ASSOCIATES

PATIENT REGISTRATION FORM

DATE:

NAME		home #
ADDRESS		work #
city-state-zip		fax #
emergency contact (name & phone #)		e mail
DATE OF BIRTH	<input type="radio"/> s <input type="radio"/> m <input type="radio"/> d <input type="radio"/> w <input type="radio"/> sep <input type="radio"/> Minor	<input type="radio"/> male <input type="radio"/> female
ARE YOU A STUDENT? <input type="radio"/> FULL TIME <input type="radio"/> PART TIME <input type="radio"/> NON-STUDENT		if student, name of school/college
WHO IS YOUR MEDICAL DOCTOR?		HOW DID YOU HEAR ABOUT OUR OFFICE?
HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? <input type="radio"/> YES <input type="radio"/> NO If YES, WHEN DID YOU LAST SEE HIM/HER?		

EMPLOYER INFORMATION

EMPLOYER	occupation
address	city-state-zip

PLEASE ANSWER THE FOLLOWING ABOUT YOUR SPOUSE, PARTNER, OR PARENT (IF YOU ARE A MINOR)

PARTNER OR PARENT NAME	occupation
PARTNER'S EMPLOYER	work phone #

INSURANCE INFORMATION

NAME OF INSURED	RELATION TO INSURED: <input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> CHILD
INSURED'S BIRTHDATE	INSURED'S SS NUMBER
INSURANCE COMPANY	POLICY #

Use the letters listed below to indicate the type and location of your pain and sensations...

KEY

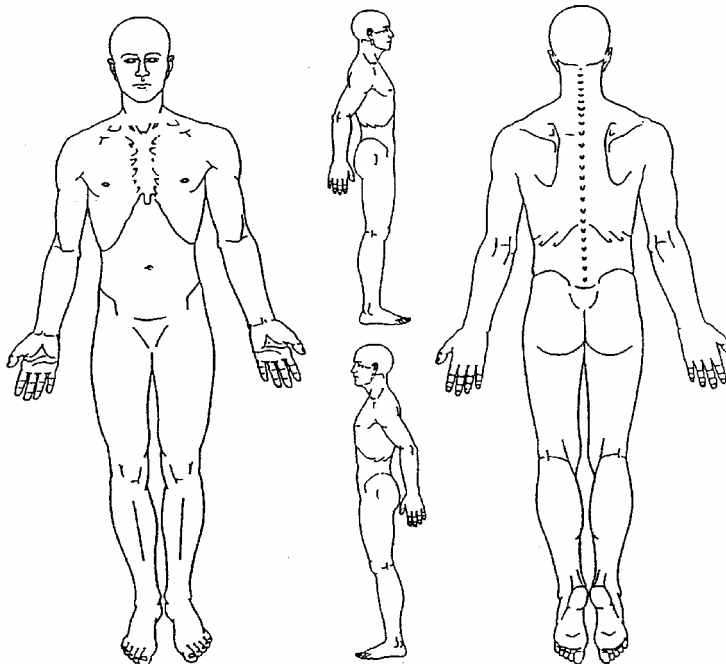
- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER

INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING TODAY

NO PAIN

SEVERE PAIN

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PLEASE LIST YOUR MAIN COMPLAINTS IN ORDER OF IMPORTANCE	SEVERITY (1-10)	ONSET DATE	% OF WAKING HOURS WITH SYMPTOMS
1.			<input type="radio"/> 0-25% <input type="radio"/> 26-50% <input type="radio"/> 51-75% <input type="radio"/> 76-100%
2.			<input type="radio"/> 0-25% <input type="radio"/> 26-50% <input type="radio"/> 51-75% <input type="radio"/> 76-100%
3.			<input type="radio"/> 0-25% <input type="radio"/> 26-50% <input type="radio"/> 51-75% <input type="radio"/> 76-100%
4.			<input type="radio"/> 0-25% <input type="radio"/> 26-50% <input type="radio"/> 51-75% <input type="radio"/> 76-100%
5.			<input type="radio"/> 0-25% <input type="radio"/> 26-50% <input type="radio"/> 51-75% <input type="radio"/> 76-100%

MEDICAL HISTORY	YOUR SELF		OTHER FAMILY	
	YES	NO		
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIST ALL YOUR MEDICATIONS: <input type="checkbox"/> NO MEDICATIONS
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEART/STROKE/ANEURYSM PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIZZINESS/EPILEPSY/CONVULSIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIST VITAMINS/HERBS YOU ARE TAKING: <input type="checkbox"/> NO VITAMINS
LIVER DISEASE/HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUNG PROBLEMS/ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MIGRAINES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NERVE DISEASE (MS,PARKINSON'S...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PROSTATE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
USUAL CHILDHOOD DISEASES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIST ALL KNOWN ALLERGIES: <input type="checkbox"/> NO ALLERGIES
UNUSUAL CHILDHOOD DISEASES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CURRENTLY PREGNANT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EXERCISE REGULARLY (2-3 TIMES/WK)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
I SMOKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PACKS/DAY				
I DRINK ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRINKS/WEEK:				

SURGERY HISTORY

	WHEN		WHEN		WHEN
APPENDIX		HEART		LUNG	
BACK SURGERY		HEMORRHOID		PROSTATE	
BLADDER		HERNIA		SHOULDER/ROTATOR CUFF	
CAESARIAN SECTION		HIP REPLACEMENT		TMJ	
CARPAL TUNNEL		HYSTERECTOMY		TONSILS/ADENOIDS	
FOOT/BUNION SURGERY		INTESTINE/BOWEL		OTHER:	
GALL BLADDER		KNEE			
HAND		KNEE REPLACEMENT			

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I DECLARE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES FOR MY TREATMENT. SERVICES ARE PAYABLE AT THE TIME RENDERED.

PATIENT OR GUARDIAN SIGNATURE

DATE

HEALTH GOALS QUESTIONNAIRE

Patient Name _____ Date _____

Which of these health goals are the most important to you? Please pick up to 5 and number them from 1 (most important) to 5 (least important).

Energy Level and Fatigue – Do you feel energetic or are you tired of being tired?

Quality of Sleep – Do you have difficulty falling or staying asleep?

Memory & Ability to Focus

Digestion – Do you have problems with reflux, heartburn, bloating, etc.?

Nutrition – How healthy is your diet?

Mood – Are you happy, anxious, sad, or depressed?

Stress Levels – How well are you handling the stresses in your life?

Allergies & Immune System – Do you take allergy medication? Are you often sick?

Understanding more about health and how you and your family can stay healthy.

Pain Control/Relief – Where is your pain?

Are there any other health goals or conditions you'd like to work on?

In what ways do you feel that your life is restricted?

BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?

Has made it no worse Has made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10