Kenley Chiropractic

"Delivering Good Health"

~ Welcome sheet ~

Patient information

Today's date: ______________________________

Patient name: ______________________________

Sex: ☐ Male ☐ Female Age: ______________

Birthdate: ________________________________

Address:

____

____

Email: ____________________________________

☐ Minor ☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Partnered for ____ years

Occupation:________________________________

Patient employer/school:______________________

Employer address:___________________________

____

Employer/school phone: (______) _______________

Spouse's name: ____________________________

Birthdate: ________________________________

Spouses employer: __________________________

Whom may we thank for referring you? ___________

Phone numbers

Home phone: (______) _______________________

Cell phone: (______) ________________________

Best time & place to reach you: ________________

In case of emergency, contact:

Name: ____________________________________

Relationship: _______________________________

Home phone: (______) _______________________

Work phone: (______) _______________________

Cell phone: (______) ________________________

Insurance

Who is responsible for this account?

____

Relationship to patient:

____

Primary insurance company: ___________________

Subscriber / Member ID: _____________________

Group #: __________________________________

Subscriber name: ___________________________

Subscriber's birthdate: _______________________

Relationship to patient: ______________________

Are you covered by additional insurance? ☐ Yes ☐ No

Secondary insurance company: _________________

Subscriber / Member ID: _____________________

Group #: __________________________________

ASSIGNMENT AND RELEASE

*I certify that I, and/or my dependent(s), have insurance coverage with ________________________________ (name of insurance company(ies)) and assign directly to **Dr. Gregg Blotner** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Blotner may use health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.*

____ ____________________

Signature of patient, parent, guardian or personal representative **Date**

____

Printed name of patient, parent, guardian or personal representative

Accident information

Is condition due to an accident? ☐ Yes ☐ No

Date of accident: ________________________________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer

Workers compensation attorney name (if applicable): ______________________________

Patient condition

Reasons for visit: ____

____

When did your symptoms appear? ____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale form 1 (least pain) to 10 (severe pain) ________

Types of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

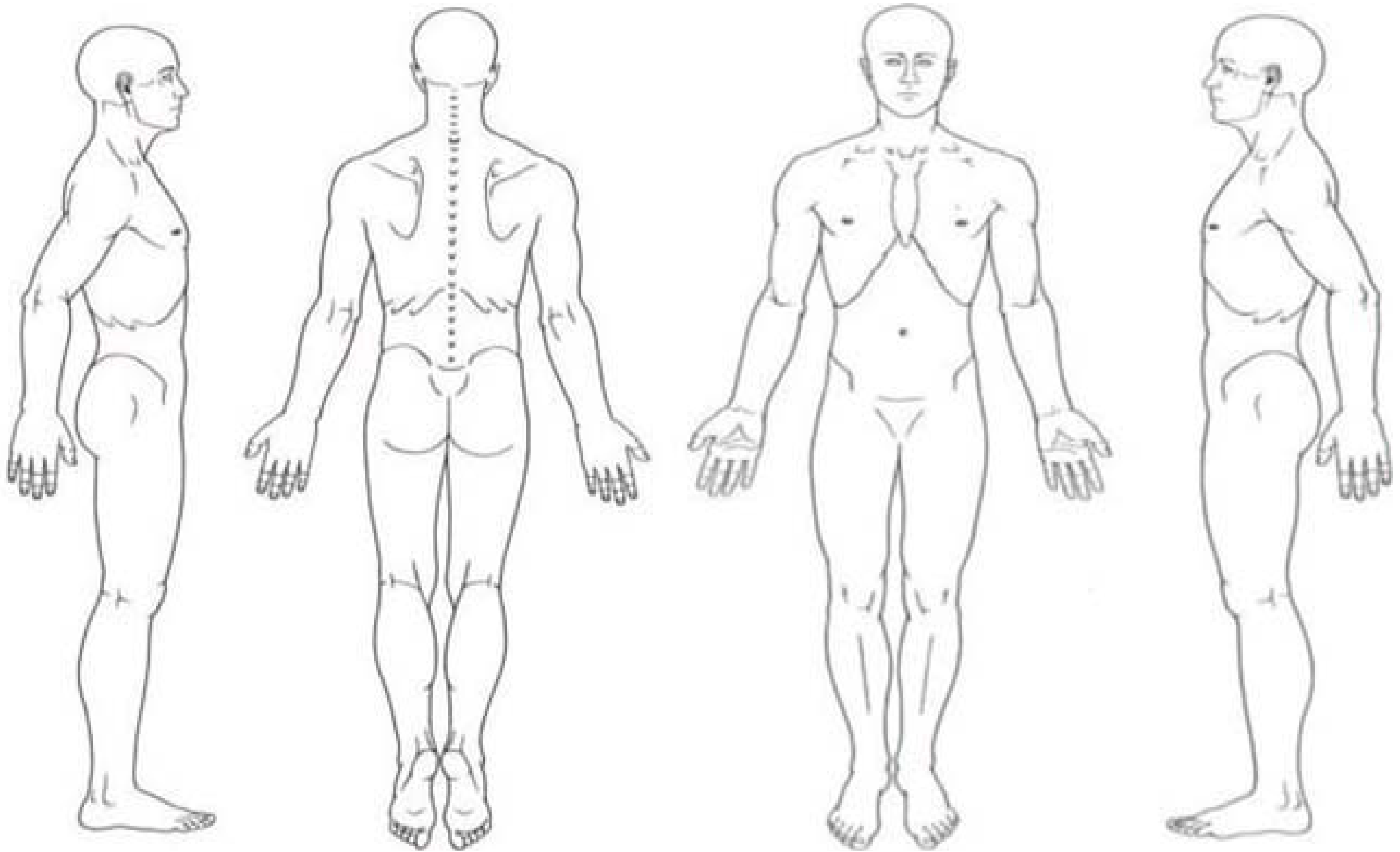
How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements which are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Please mark an X on the picture where you continue to have pain, numbness or tingling:



What treatments have you already received for this condition? ____

____

Name and address of doctor(s) who have treated you for this condition: ______________________________________

____

Are you pregnant? ☐ **Yes** ☐ **No** **If yes, when is your due date?** ______________________________

<u>Injuries and surgeries you have had in the last 10 years</u>

Falls: ____

Head injuries: ____

Broken bones: ____

Dislocations: ____

Surgeries: ____

<u>Medications you are currently taking</u>

____

____

<u>Allergies</u>

____

Exercise	**Work activity**	**Habits**	
☐ None	☐ Sitting	☐ Smoking	(packs per day: _______)
☐ Moderate	☐ Standing	☐ Alcohol	(drinks per day: _______)
☐ Daily	☐ Light Labor	☐ Coffee/caffeine	(cups per day: ________)
☐ Heavy	☐ Heavy Labor	☐ High stress level	(reason ____________________________)

Place an X in the box "Yes" or "No" to indicate if you have ever had any of the following:

AIDS/HIV	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Allergy shots	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Herniated disk	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Measles	☐ Yes	☐ No
Breast lump	☐ Yes	☐ No	Migraine headaches	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Mult. sclerosis	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Chicken pox	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pinched nerve	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Prostate problem	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Psych. care	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Goiter	☐ Yes	☐ No	Suicide attempt	☐ Yes	☐ No
Gonorrhea	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No

By signing this form, I attest this is true to the best of my knowledge and have in no way knowingly misrepresented any information listed on this form.

____ ________________

Signature of patient, parent, guardian or personal representative **Date**

____

Printed name of patient, parent, guardian or personal representative