

Kenley Chiropractic

"Delivering Good Health"

~ Welcome sheet ~

Patient Information

Date: _____

Patient name: _____

Address: _____

Email: _____

Sex: Male Female Age: _____

Birthdate: _____

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:

Insurance company:

Subscriber / Member ID:

Group #

Subscriber name:

Subscriber's birthdate: _____

Relationship to patient: _____

Is patient 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

Date

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 from 1 (least pain) to 10 (severe pain) _____

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

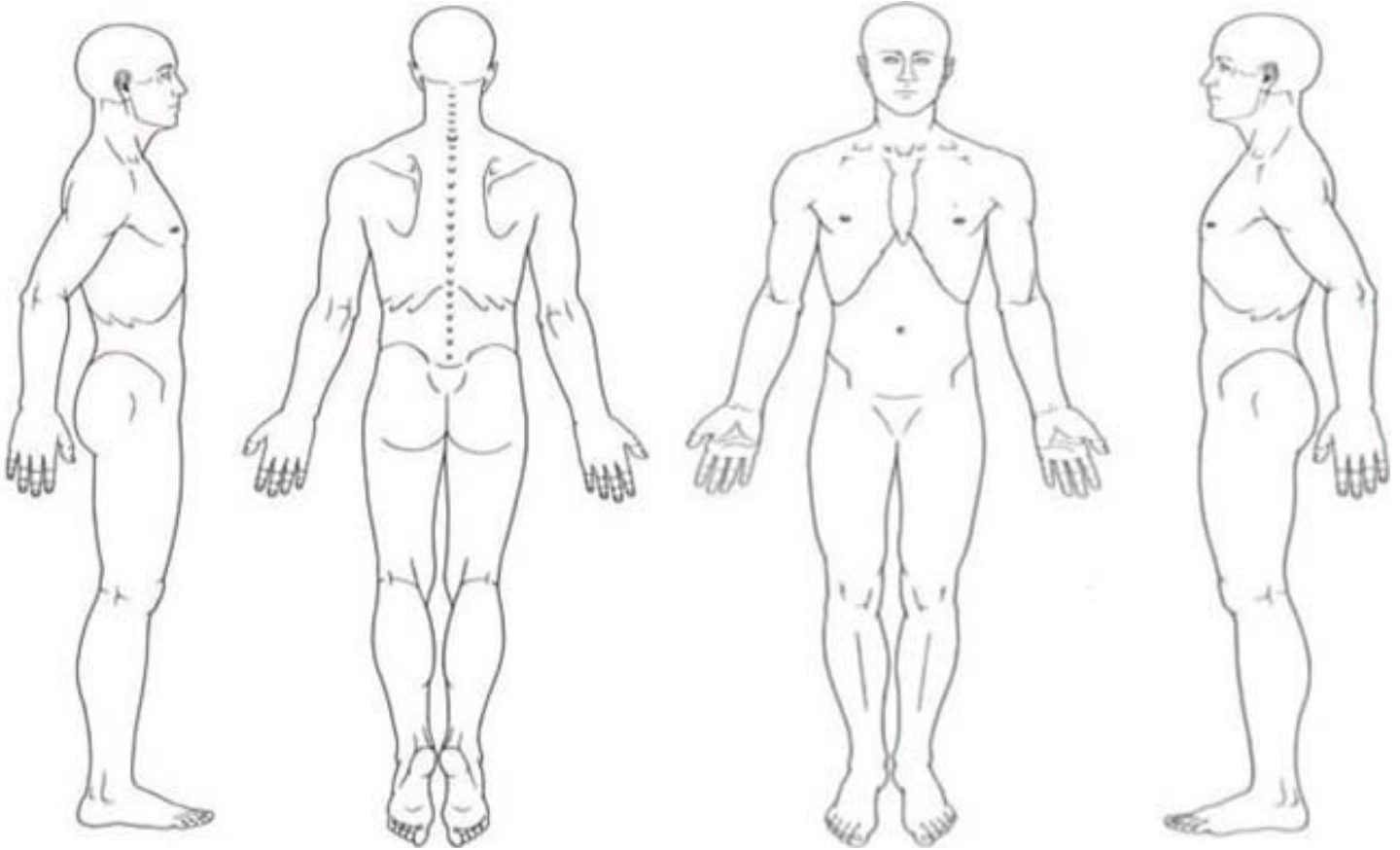
How often do you have this pain? _____

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? _____

Injuries and surgeries you have had in the last 10 years

Falls: _____

Head injuries: _____

Broken bones: _____

Dislocations: _____

Surgeries: _____

Medications you are currently taking

Allergies

Exercise**Work Activity****Habits**

- | | | |
|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Sitting | <input type="checkbox"/> Smoking (packs per day: _____) |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Standing | <input type="checkbox"/> Alcohol (drinks per day: _____) |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Light Labor | <input type="checkbox"/> Coffee/caffeine (cups per day: _____) |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Heavy Labor | <input type="checkbox"/> High stress level (reason _____) |

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

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

Date