

Kojis Chiropractic, PS

The following information is needed for our files so that we may better serve you.
Please complete this form as neatly and accurately as possible.

PERSONAL

Name _____ Date of Birth _____ Sex M F Marital Status M S W D

Address _____ City _____ State _____ Zip _____

Who referred you to our office? _____ Occupation _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

What is the best time to reach you by phone? Home _____ Work _____

Have you received Chiropractic care previously? No Yes

If yes, who was the Doctor? _____ When was your last visit? _____

Do you know what types of adjustments or what techniques or methods he/she used? _____

Why did you discontinue care? _____

PHYSICAL

1. Have you, even as a passenger, and even if you feel you were not hurt, been involved in a motor vehicle accident? No Yes

Approximate dates and severity (mild, moderate, extreme) _____

2. Have you been hurt during any sport or leisure activities? No Yes When? _____

3. Do you play a musical instrument? No Yes Which? _____

4. Do you have a particular position for watching TV? No Yes _____

5. Are you in one position for prolonged periods of time at your work? No Yes What is it? _____

6. Have you ever been knocked unconscious? No Yes _____

7. Have you ever used crutches, a cane, or a walker? No Yes _____

8. Have you ever had a broken bone or body part immobilized in a cast? No Yes _____

9. Have you ever had a hard fall onto your tail bone? No Yes _____

10. Have you ever had an impact, fall or jolt that may have injured your spine? No Yes _____

11. Have you had extensive dental or orthodontic work? No Yes _____

MEDICAL TREATMENT

13. Have you been hospitalized? No Yes If yes, why, and what was actually done to you? _____

14. Have you had surgery? No Yes What type? _____
15. Do you still have all your body parts? No Yes _____
16. Have you had (check those which apply): Spinal tap Spinal injections Physical therapy Neck collar Spinal brace
 Traction Heel lift X-ray treatment Extensive diagnostic x-rays Acupuncture Chemotherapy
17. Have you ever been diagnosed or treated for (check those which apply): Cancer HIV Polio High blood pressure
 Heart trouble Stroke Dizziness Asthma Digestive trouble Menstrual problems Prostate problems

CHEMICAL

18. Are you taking any non-prescription drugs? No Yes Which ones and how often? _____

19. Are you taking any prescription drugs? No Yes Please list _____

20. Are these drugs being prescribed by a physician? No Yes Who? _____
When was your last visit? _____
21. Have you previously taken any drug, prescription or over the counter, regularly? No Yes Which? _____
22. Do you work with chemicals, fumes, dust, powders, or smoke for prolonged periods? No Yes _____
23. Do you use tobacco? No Yes What form? _____ How much? _____
24. The type of diet you usually follow could be described as _____

MENTAL/EMOTIONAL

25. Please relate if and how the following mental/emotional stress situations apply to your life:

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Financial stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play or recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of a loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Life style change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in Vocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concern about health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. How do you rate your present physical health?
 Excellent Good Fair Getting better Getting worse
27. How do you rate your present mental/emotional health?
 Excellent Good Fair Getting better Getting worse

28. Do you consider yourself ill? No Yes If yes why? _____

29. Is there anything else you wish for us to know that might help us understand you better? _____

31. What is your goal in coming to our office? _____

This person is a minor. Permission is given by me to the doctors of this office to render care. I am this person's legal guardian.

Signature _____ **Date** _____