ABOUT THE PATIENT Keltgen Family Chiropractic

Name ______________________ Today's Date __________ Birthdate __________ Age ______
Address ______________________ City ______________ State ______ Zip __________
Home Phone ______________ Cell Phone ______________ Work Phone ______________ Gender ☐ M ☐ F
Significant Other's Name ______________________ Kid's Names and Ages ______________________
Your Employer ______________________ Type of Work ______________________
e-Mail Address ______________________ Have you been to a chiropractor before? ☐ No ☐ Yes
Emergency Contact ______________________ PH # ______________________
Name of Medical Doctor(s) ______________________
Name of Insurance Company ______________________ .
How did you hear about our office? ______________________.

- I authorize the doctor or their staff to render care as deemed appropriate for me and / or my child.
- I authorize Keltgen Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? ______________________
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: __Cash __Check __Credit Card __Car/Work Ins.

______________________ ______________________
Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

PRESENT COMPLAINTS

1. ______________________ How long has this been an issue? ______________
   Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
   ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to______________
2. ______________________ How long has this been an issue? ______________

7. What makes it worse? ______________________
8. What Doctor's have you seen for this? ______________________
____
9. Type of treatment: ______________________
10. Results: ______________________

NOTES: ______________________
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Please mark All areas of concern.

Are you pregnant?

☐ Yes ☐ No