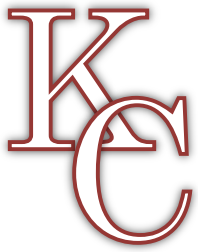
Date _____ Doctor _____



KIEKHOEFER CHIROPRACTIC

8619 West Point Douglas Rd., Suite 110
Cottage Grove, MN 55016
651-458-0094

New Patient Form

Welcome To Our Office

PATIENT REGISTRATION

Last Name_____ First Name _____M.I._____ Nickname _____
Date of Birth _____ Age _____ SEX: M F
Address _____
City/State/Zip _____
Phone (home) _____ (Cell) _____
E-mail _____
Occupation _____ Employer_____
Marital status ____ Single ____ married ____divorced ____widowed
Spouse's name _____ Phone _____
Are you pregnant? ____ Yes ____ No If Yes, how many weeks? _____
Children (names, ages) _____
_____
Most of our patients are referred by a family member or friend, how did you find out about our office?
Name of referring family member or friend _____
Yellow Pages _____ Website _____ Sign _____ Other _____

Emergency Contact: Name _____
Relationship _____ Phone # (s) _____

PURPOSE FOR THIS VISIT

Is this appointment related to ____ work ____ sports ____ auto
____ personal injury ____ other _____

What are your most pressing health concerns? _____
_____
_____

When did the condition begin? _____
What activities aggravate your symptoms? _____
Is there anything that has relieved your symptoms? Yes No Describe_____
_____

Type of pain: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting

Does the pain radiate into your arms or legs? Yes No

Is the condition: ____ getting worse ____ improving ____intermittent ____constant ____can't say

Frequency of symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Do your symptoms interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain_____
_____

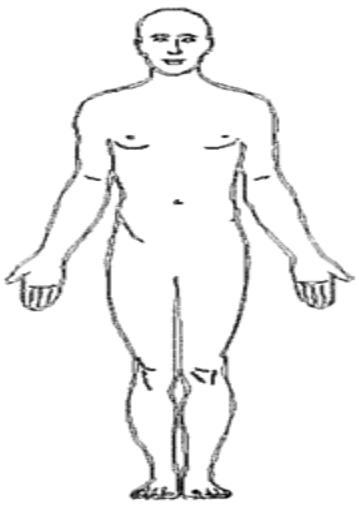
Have you experienced this condition before? Yes No if Yes, please explain_____
_____

Who have you seen for this?_____ What did they do? _____
How did you respond?_____

Are you receiving care from other health professionals? ____ Yes ____ No
If yes, please name them and their specialty _____
_____

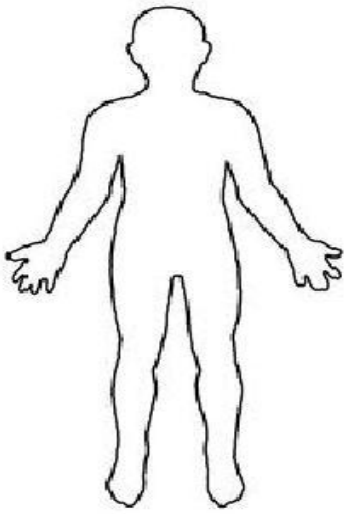
Please list any drugs or medications you are taking _____
_____
Please list any vitamins/herbs/homeopathics/other you are taking _____
_____

Where is the problem? Please use the illustrations and lines below to explain.



Front _____
_____
_____
_____

Back _____
_____
_____
_____



On a scale of 1-10 (1 least, 10 most), please rate:
The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Do you have, or have you had, any of the following (please check all that apply)

pneumonia ☐	mumps ☐	influenza ☐	rheumatic fever ☐	smallpox ☐
pleurisy ☐	polio ☐	chickenpox ☐	thyroid disease ☐	diabetes ☐
epilepsy ☐	cancer ☐	depression ☐	whooping cough ☐	anemia ☐
eczema ☐	measles ☐	arthritis ☐	heart disease ☐	rashes ☐

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use ____ coffee _____ tea ____ alcohol ____ cigarettes ___ recreational drugs

Have you ever suffered from (please check all that apply)

neck pain ☐	stuffy nose ☐	discolored urine ☐
low back pain ☐	allergies ☐	gas/bloating after meals ☐
headaches ☐	fainting ☐	heartburn ☐
migraines ☐	weight loss ☐	colitis ☐
arms back/tingling ☐	poor appetite ☐	irritable bowel ☐
shoulder pain ☐	excessive appetite ☐	black or bloody stools ☐
hand pain/tingling ☐	nervousness ☐	constipation ☐
leg pain/tingling ☐	confusion ☐	hemorrhoids ☐
jaw pain ☐	depression ☐	liver problems ☐
chest pain ☐	dental problems ☐	stroke ☐
lung problems ☐	excessive thirst ☐	paralysis ☐
heart problems ☐	frequent nausea ☐	tingling ☐
abnormal blood pressure ☐	vomiting ☐	numbness ☐
irregular heartbeat ☐	prostate problem ☐	fatigue ☐
ankle swelling ☐	breast pain/lump ☐	dizziness ☐
cold extremities ☐	cramps ☐	loss of sleep ☐
blurred vision ☐	painful urination ☐	difficulty hearing ☐
vision problems ☐	bladder trouble ☐	ear pain ☐
difficulty breathing ☐	excessive urination ☐	

Past injuries can affect present health (please check all that apply)

falls/accidents ☐	head injuries ☐	fights ☐
sports injuries ☐	broken bones ☐	dislocations ☐
spinal tap ☐	surgery ☐	traction ☐
use(d) a cane or walker ☐	extensive dental work ☐	dental appliances ☐
knocked unconscious ☐		

If yes to any of the above, please describe _____

_____

_____

EXPERIENCE WITH CHIROPRACTIC

Have you ever had chiropractic care before? ____ Yes ____ No
If yes, please tell us the doctor's name _____
In your own words, what do chiropractors do? _____
_____
Do you know what spinal nerve stress/subluxation is? ____ Yes ____ No
If yes, please describe _____
_____
_____
Do any friends or relatives see chiropractors? ____ Yes ____ No
If yes, do they use chiropractors for ____ wellness
____ health problems ____ both
Are you seeking chiropractic for ____ wellness
____ health problems ____ both

What would you like to gain from chiropractic care? _____
_____
_____

Are there other health concerns or anything else you'd like us to know about you?
____ Yes ____ No If yes, please tell us. _____
_____
_____
_____
Notes _____
_____
_____
_____

The above information is accurate to the best of my knowledge.

_____ _____
Signature Date

I, parent/guardian, give permission for minor's care.

_____ _____
Signature Date