



# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.  
All information you supply is confidential. We comply with all federal privacy standards.  
Please print clearly.

**King Chiropractic**  
**Dr. Rich King, DC**  
11946 W. 95<sup>th</sup> St.  
Lenexa, KS 66215  
913-599-5464 - Phone  
913-599-5465 - Fax  
www.drrichking.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No  Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name

Your Social Security Number

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender

Male  Female

Race

Address

Marital Status  Married

Ethnicity

Single  Divorced

City

State/Province

ZIP/Postal Code

Widowed  Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes  No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone

Primary Care Provider's Name

Work Phone  Email

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self  Spouse  Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: \_\_\_\_\_

2. And are the result of (darken circle):  An accident or injury  
 Work  Auto  Other \_\_\_\_\_  
 A worsening long-term problem  
 An interest in:  Wellness  Other \_\_\_\_\_

3. Onset (When did you first notice your current symptoms?)

4. Intensity (How extreme are your current symptoms?)



5. Duration and Timing (When did it start and how often do you feel it?)

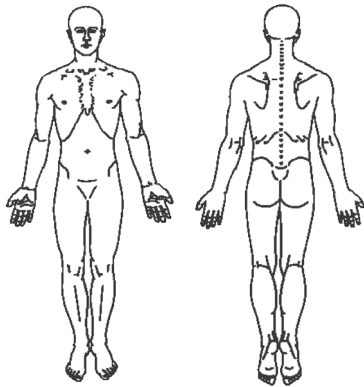
Constant  Comes and goes. How Often? \_\_\_\_\_

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other \_\_\_\_\_

7. Location (Where does it hurt?)

Circle the area(s) on the illustration.  
"0" for current condition  
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? \_\_\_\_\_

What tends to lessen the problem? \_\_\_\_\_

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication  Surgery  Ice
- Over-the-counter drugs  Acupuncture  Heat
- Homeopathic remedies  Chiropractic  Other \_\_\_\_\_
- Physical therapy  Massage \_\_\_\_\_

11. What else should Dr. King know about your current condition? \_\_\_\_\_

12. How does your current condition interfere with your:

Work or career: \_\_\_\_\_

Recreational activities: \_\_\_\_\_

Household responsibilities: \_\_\_\_\_

Personal relationships: \_\_\_\_\_

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right.

a. Musculoskeletal

- Had  Have  Osteoporosis
- Had  Have  Arthritis
- Had  Have  Scoliosis
- Had  Have  Neck pain
- Had  Have  Back problems
- Had  Have  Hip disorders
- NONE
- Had  Have  Knee injuries
- Had  Have  Foot/ankle pain
- Had  Have  Shoulder problems
- Had  Have  Elbow/wrist pain
- Had  Have  TMJ issues
- Had  Have  Poor posture
- Initials \_\_\_\_\_

b. Neurological

- Had  Have  Anxiety
- Had  Have  Depression
- Had  Have  Headache
- Had  Have  Dizziness
- Had  Have  Pins and needles
- Had  Have  Numbness
- NONE
- Initials \_\_\_\_\_

c. Cardiovascular

- Had  Have  High blood pressure
- Had  Have  Low blood pressure
- Had  Have  High cholesterol
- Had  Have  Poor circulation
- Had  Have  Angina
- Had  Have  Excessive bruising
- NONE
- Initials \_\_\_\_\_

d. Respiratory

- Had  Have  Asthma
- Had  Have  Apnea
- Had  Have  Emphysema
- Had  Have  Hay fever
- Had  Have  Shortness of breath
- Had  Have  Pneumonia
- NONE
- Initials \_\_\_\_\_

e. Digestive

- Had  Have  Anorexia/bulimia
- Had  Have  Ulcer
- Had  Have  Food sensitivities
- Had  Have  Heartburn
- Had  Have  Constipation
- Had  Have  Diarrhea
- NONE
- Initials \_\_\_\_\_

f. Sensory

- Had  Have  Blurred vision
- Had  Have  Ringing in ears
- Had  Have  Hearing loss
- Had  Have  Chronic ear infection
- Had  Have  Loss of smell
- Had  Have  Loss of taste
- NONE
- Initials \_\_\_\_\_

g. Skin

- Had  Have  Skin cancer
- Had  Have  Psoriasis
- Had  Have  Eczema
- Had  Have  Acne
- Had  Have  Hair loss
- Had  Have  Rash
- NONE
- Initials \_\_\_\_\_

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

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**h. Endocrine**

- Had  Have  Thyroid issues    Had  Have  Immune disorders    Had  Have  Hypoglycemia    Had  Have  Frequent infection    Had  Have  Swollen glands    Had  Have  Low energy    NONE

Initials \_\_\_\_\_

**i. Genitourinary**

- Had  Have  Kidney stones    Had  Have  Infertility    Had  Have  Bedwetting    Had  Have  Prostate issues    Had  Have  Erectile dysfunction    Had  Have  PMS symptoms    NONE

Initials \_\_\_\_\_

**j. Constitutional**

- Had  Have  Fainting    Had  Have  Low libido    Had  Have  Poor appetite    Had  Have  Fatigue    Had  Have  Sudden weight gain/loss (circle one)    Had  Have  Weakness    NONE

Initials \_\_\_\_\_

Patient name \_\_\_\_\_

Patient Number (office use only) \_\_\_\_\_

All other systems negative

**Past Personal, Family and Social History**

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

<b>PERSONAL</b>	<b>14. Illnesses</b> Check the illnesses you have <b>Had</b> in the past or <b>Have</b> now.	<b>15. Operations</b> Surgical interventions, which may or may not have included hospitalization.	<b>16. Treatments</b> Check the ones you've received in the <b>Past</b> or are receiving <b>Currently</b> .
	Had <input type="radio"/> Have <input type="radio"/> AIDS	Had <input type="radio"/> Have <input type="radio"/> Tuberculosis	<b>Past</b> <input type="radio"/> <b>Currently</b> <input type="radio"/> Acupuncture
	Had <input type="radio"/> Have <input type="radio"/> Alcoholism	Had <input type="radio"/> Have <input type="radio"/> Typhoid fever	<input type="radio"/> Antibiotics
	Had <input type="radio"/> Have <input type="radio"/> Allergies	Had <input type="radio"/> Have <input type="radio"/> Ulcer	<input type="radio"/> Birth control pills
	Had <input type="radio"/> Have <input type="radio"/> Arteriosclerosis	Had <input type="radio"/> Have <input type="radio"/> Other: _____	<input type="radio"/> Blood transfusions
	Had <input type="radio"/> Have <input type="radio"/> Cancer		<input type="radio"/> Chemotherapy
	Had <input type="radio"/> Have <input type="radio"/> Chicken pox		<input type="radio"/> Chiropractic care
	Had <input type="radio"/> Have <input type="radio"/> Diabetes	<b>17. Allergies</b> Are you allergic to any medications?	<input type="radio"/> Dialysis
	Had <input type="radio"/> Have <input type="radio"/> Epilepsy	<b>Yes</b> <input type="radio"/> <b>No</b> <input type="radio"/> If Yes please list: _____	<input type="radio"/> Herbs
	Had <input type="radio"/> Have <input type="radio"/> Glaucoma		<input type="radio"/> Homeopathy
	Had <input type="radio"/> Have <input type="radio"/> Goiter		<input type="radio"/> Hormone replacement
	Had <input type="radio"/> Have <input type="radio"/> Gout		<input type="radio"/> Inhaler
	Had <input type="radio"/> Have <input type="radio"/> Heart disease		<input type="radio"/> Massage therapy
	Had <input type="radio"/> Have <input type="radio"/> Hepatitis		<input type="radio"/> Physical therapy
	Had <input type="radio"/> Have <input type="radio"/> HIV Positive		<input type="radio"/> Medications
Had <input type="radio"/> Have <input type="radio"/> Malaria		<small>(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):</small>	
Had <input type="radio"/> Have <input type="radio"/> Measles		_____	
Had <input type="radio"/> Have <input type="radio"/> Multiple Sclerosis		_____	
Had <input type="radio"/> Have <input type="radio"/> Mumps		_____	
Had <input type="radio"/> Have <input type="radio"/> Polio	<b>18. Injuries</b> Have you ever...	_____	
Had <input type="radio"/> Have <input type="radio"/> Rheumatic fever	<input type="radio"/> Had a fractured or broken bone	<input type="radio"/> Used a crutch or other support	
Had <input type="radio"/> Have <input type="radio"/> Scarlet fever	<input type="radio"/> Had a spine or nerve disorder	<input type="radio"/> Used neck or back bracing	
Had <input type="radio"/> Have <input type="radio"/> Sexually transmitted disease	<input type="radio"/> Been knocked unconscious	<input type="radio"/> Received a tattoo	
Had <input type="radio"/> Have <input type="radio"/> Stroke	<input type="radio"/> Been injured in an accident	<input type="radio"/> Had a body piercing	

Consultation Notes

**19. Family History**

Some health issues are hereditary. Tell Dr. King about the health of your immediate family members.

<b>FAMILY</b>	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

**20. Are there any other hereditary health issues that you know about?** \_\_\_\_\_

**21. Social History**

Tell Dr. King about your health habits and stress levels.

<b>SOCIAL</b>	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies:	_____			

Doctor's Initials \_\_\_\_\_

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**22. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name \_\_\_\_\_

Patient Number  
(office use only) \_\_\_\_\_

23. What is the major stressor in your life? \_\_\_\_\_ 24. How much sleep do you average per night? \_\_\_\_\_ Hours

25. What is the type and approximate age of your mattress and pillow? \_\_\_\_\_ 26. What is your preferred sleeping position? \_\_\_\_\_

27. Describe your typical eating habits:  Skip breakfast  Two meals a day  Three meals a day  Snacking between meals

28. What would be the most significant thing that you could do to improve your health? \_\_\_\_\_

29. In addition to the main reason for your visit today, what additional health goals do you have? \_\_\_\_\_

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials \_\_\_\_\_ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials \_\_\_\_\_ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials \_\_\_\_\_ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): \_\_\_\_\_**

Initials \_\_\_\_\_ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials \_\_\_\_\_ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials \_\_\_\_\_ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: \_\_\_\_\_

Signature \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_

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Doctor's Initials \_\_\_\_\_

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