Welcome to Krueger Family Chiropractic!

We would like to take this opportunity to welcome you to our office. Hopefully you are here because you heard of our great reputation. Our office is known for being a friendly casual place where people come to get healthy. As far as we are concerned, we will do everything possible to give you the best care we could possibly give. **We treat our patients as if they are our very own family.** Thank you for choosing Krueger Family Chiropractic. We look forward to helping you! *Drs. Jeff & Stephanie Krueger & the staff of Krueger Family Chiropractic*

Chiropractic Case History / Patient Information

Date:__________________

Last Name:____________________________ First Name:__________________________ Middle Initial:_______

Social Security #__________________Home Phone: _________________ Cell Phone:_____________________

Address:____City:____________________ State:_______

Zip:___________E-mail address: ______________________________________ (monthly newsletter will be sent)

Age:_________ Birth Date:_____________________ Marital Status: M S W D

Occupation:_________________________ Employer:____

Employer's Address:___________________________________ Office Phone:_____________________________

Spouse:____ Spouse's Birth Date:____________________

Spouse's Occupation:___________________________Spouse's Employer:_______________________________

How many children?____________Names and Ages of Children:____

____

Emergency Contact: _______________________________ Phone:__________________

DEMOGRAPHICS: (please circle) *(US government is now requiring we ask Demographic information)*

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: White American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander Two or more

What is your preferred method of contact?

Phone number:____________________ **Home Work Cell Phone call** ______(Y/N) **Text**________(Y/N)

Preferred Language: English Spanish French German Italian Mandarin Cantonese Tagalog Japanese Other

How were you referred to our office?____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? **Yes** ____ **No**____

Family Medical Doctor:________________________________ **Facility**__________________________________

HEALTH ASSESSMENT OF PRESENT ILLNESS:

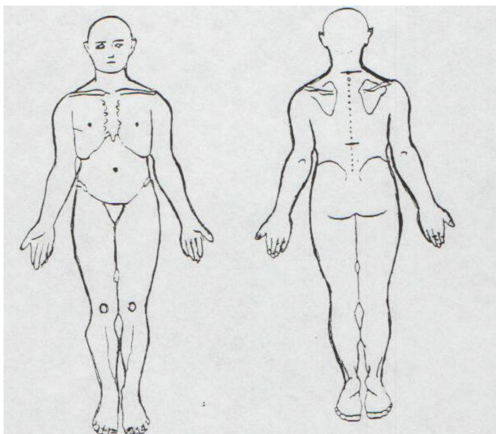
Chief Complaint: Purpose of this appointment:____

Date symptoms appeared or how long had this problem:____

How do you think your problem began? ____

Is today's problem caused by: ___Auto Accident ____Workman's Compensation

Please mark an X or circle the area on the picture below where you have pain, numbness, or tingling.



How are your symptoms changing with time?

___ Getting Worse ____Staying the Same ___Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

How often do you experience your symptoms?

____Constantly (76-100% of the time) ____Occasionally (26-50% of the time)

____Frequently (51-75% of the time) ____Intermittently (1-25% of the time)

How would you describe the type of pain?

___Sharp ___Numb ___Dull ___Tingly

___Diffuse ___Achy ___Stiff ___Burning

___Shooting ___Stiff ___Sharp with motion

___Shooting with motion ___Stabbing with motion ___Electric with motion ___Other:________________

How much has the problem interfered with your work?

___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

How much has the problem interfered with your social activities?

___Not at all ___A little bit ___Moderately ___Quite a bit ___Extremely

What aggravates your problem? ____

What is your approximate: Height___________ **Weight**_____________

Who else have you seen for your problem?

___Chiropractor ___Neurologist ___Physical Therapist ___Primary Care Physician

___ER Physician ___Orthopedist ___Massage Therapist ___Other:_______________

What concerns you most about your problem; what does it prevent you from doing?

____

How would you rate your overall Health?

____Excellent ____Very Good ____Good ____Fair ____Poor

What type of exercise do you do?

____Strenuous ____Moderate ____Light ____None

Smoking Status: ___Smokes Every Day ___Smokes Some Days ___Former Smoker ____Never Smoked

Indicate if you have any immediate family members with any of the following:

____Diabetes ____Heart Problems ____Cancer ____Rheumatoid Arthritis

____Stroke ____Lupus ____ALS

For each of the conditions listed below, pace a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
__	__Headaches	__	__High Blood Pressure	__	__**Diabetes**
__	__Neck Pain	__	__Heart Attack	__	__Excessive Thirst
__	__Upper Back Pain	__	__Chest Pains	__	__Frequent Urination
__	__Mid Back Pain	__	__Stroke	__	__Smoking/Tobacco Use
__	__Low Back Pain	__	__Angina	__	__Drug/Alcohol Dependence
__	__Shoulder Pain	__	__Kidney Stones	__	__Allergies
__	__Elbow/Upper Arm Pain	__	__Kidney Disorders	__	__Depression
__	__Wrist Pain	__	__Bladder Infection	__	__Systemic Lupus
__	__Hand Pain	__	__Painful Urination	__	__Epilepsy
__	__Hip Pain	__	__Loss of Bladder Control	__	__Dermatitis/Eczema/Rash
__	__Upper Leg Pain	__	__Prostate Problems	__	__HIV/AIDS
__	__Knee Pain	__	__Abnormal Weight Gain/Loss		
__	__Ankle/Foot Pain	__	__Loss of Appetite		**For Females Only**
__	__Jaw Pain	__	__Abdominal Pain	__	__Birth Control Pills
__	__Joint Pain/Stiffness	__	__Ulcer	__	__Hormonal Replacement
__	__Arthritis	__	__Hepatitis	__	__Pregnancy
__	__Rheumatoid Arthritis	__	__Liver/Gall Bladder Disorder		
__	__Cancer	__	__General Fatigue		
__	__Tumor	__	__Muscular Incoordination		
__	__**Asthma**	__	__Visual Disturbances		
__	__Chronic Sinusitis	__	__Dizziness		
__	__Other:____				

List all Prescription medications you are currently taking:

Medication:	**#of refills:**	**Quantity of Pills:**	**Strength:** (i.e. 10mg)	**Dose Form:** (capsule)	**Instruction:** (1/day)
_______________	_____	_______	__________	_____________	_______________
_______________	_____	_______	__________	_____________	_______________
_______________	_____	_______	__________	_____________	_______________
_______________	_____	_______	__________	_____________	_______________

Are you allergic to any medicines? Please list each drug on a new line:
Name of Drug: (i.e. Penicillin) **Symptom:** (i.e Headache)

_______________________________ ____
_______________________________ ____

List all over-the-counter medications you are currently taking: (including supplements)
____

List all surgical procedures you have had:
____

What activities do you at work?

___Sit: ___Most of the day ___Half of the day ___A little of the day
___Stand: ___Most of the day ___Half of the day ___A little of the day
___Computer Work: ___Most of the day ___Half of the day ___A little of the day
___On the Phone: ___Most of the day ___Half of the day ___A little of the day

What activities do you do outside of work?
____

Have you ever been hospitalized? ___No ___Yes
If yes, Why? ____
Have you had significant past trauma? ___No ___Yes
Anything else pertinent to your visit today? ____
I would like to electronically have access to my health information: (please initial if yes) ______________

GUARANTOR INFORMATION:

Please circle any and all insurance coverage that may be applicable in this case**:**
Health Insurance Medicaid Medicare Worker's Compensation Auto Accident
Medical Savings Account & Flex Plans Other (please list) ____
Name of Primary Insurance Company ____
Name of Secondary Insurance Company (if any) ____
Who is responsible for this account? ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Krueger or Krueger Family Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:_____________________________________ Date:________________

WOMEN ONLY – X-RAY CONSENT:

Are you pregnant or is there any possibility you may be pregnant? Yes _____ No _____ Uncertain _____

I, ___________________________, agree to receive any necessary x-rays. I understand that x-rays could be harmful if I was pregnant and by signing below to the best of my knowledge I confirm that I am not pregnant.

Patient's Signature:____ Date:________________