Welcome: *To Krause Family Chiropractic*

Patient Information

Date________________

Name ____

Address ____

(City State Zip) ______________________________________

Gender: ☐M ☐F Age ______ Birthdate _____________

Patient SS#____

Home Phone _____________________________________

Work Phone _____________________________________

Cell Phone ____

E-mail Address____________________________________

Occupation _____________________________________

Employer____

Spouse's Name___________________________________

Spouse's Phone # _________________________________

Children's names, ages ___________________________

____

*Whom may we thank for referring you to our office?

____

*Have you had chiropractic care before? ☐Yes ☐No

Insurance/

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________

and assign directly to Dr. Krause / Dr. Burkholder all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X________________________ Date_______________

Responsible party signature

Insurance Holders' Name __________________________

SS#___________________ Birth date _______________

Phone #_________________________

Consent

I hereby give consent for myself or my dependent/child to be examined and/or treated by Dr. Krause or Dr. Burkholder and understand that I am financially responsible for all services rendered.

X__________________________ Date_______________

Patient or Guardian

Accident Information

Is your condition due to an accident? ☐Yes ☐No

Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Workers' comp.

Current History

Briefly describe the reason for you visit:

Exercise

☐None ☐Moderate

☐Daily ☐Heavy

Describe:

Work Activity

☐Sitting ☐Standing

☐Light Labor ☐Heavy Labor

Describe:

Habits

☐Smoking ……………. Packs/Day_____________

☐Alcohol……………… Drinks/Week___________

☐Coffee ……………….Cups/Day______________

☐High Stress Level……Reason___________________

Medications

1. ______________________________________
2. ______________________________________
3. ______________________________________

*If more space is needed please use back or provide list

Females Only: Are you Pregnant? ☐Yes ☐ No

Past History

*Injuries/Surgeries Describe Date

Falls ____

Head injuries _____________________________________

Fracture/Dislocation _______________________________

List All Auto Accidents _____________________________

Surgeries _______________________________________

Do *you* or *your family* have a history of:

☐ Cancer	☐ Alcoholism	☐ Pinched Nerve
☐ Heart Disease	☐ Drug Addiction	☐ Psychiatric Care
☐ Diabetes	☐ Concussions	☐ Leukemia
☐ Tumors	☐ Migraines	☐ Other________
☐ Arthritis	☐ Asthma	_______________
☐ Ulcers	☐ Scoliosis	_______________
☐ Stroke	☐ Herniated Disc	_______________