

King Chiropractic of Florence

Family & Sports Chiropractic * Pain Recovery * Work & Auto Injury Recovery * Health Coaching

John K. King, D.C.

Patient's Name _____ Date: _____
Birthdate _____ Gender _____ Marital Status _____ Race _____
Language _____ (circle one) Hispanic/Latino Not Hispanic/Latino Decline to answer
Soc. Sec. No. _____ Spouse's Name _____
Home Phone _____ Cell Phone _____ Work Phone _____
E-mail address _____ Occupation _____
Home Address _____

Who referred you to our office? _____ May we thank them? _____
Previous doctors seen for your current complaints _____

General Health Review

Medical History: Please Circle Any That Apply

Heart Disease Stroke Cancer Arthritis Diabetes Hypertension
Psychiatric High Cholesterol Kidney Dis. Liver Disease Stomach/Intestinal Disease

Please Explain: _____

Your Family Physician: _____

Past Surgical History: Please List All Your Past Surgeries and Results (Include Cosmetic such as breast implants & Child Delivery such as caesarian section)

1. _____ Date _____ Results _____
2. _____ Date _____ Results _____
3. _____ Date _____ Results _____

Have you ever been hospitalized? Yes or No Date _____ Reason _____

Current Medications / Vitamins: Please List All Current Medications/Vitamins

Name of Medication	Dosage	Strength	Frequency
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Past Medications: Please List All Medications You Have Tried In The Past For This Problem.

1. _____ 4. _____
2. _____ 3. _____

Allergies: Please List All types of allergies or Classes Of Medication To Which You Are Allergic

1. _____ Reaction? _____
2. _____ Reaction? _____

Height _____ Weight _____

Social History

With whom do you live? Circle All That Apply

Spouse Child(#___) Mother Father Siblings (#___) Roommate (#___) Grandparent (#___)

Other Relative _____ Other Legal Guardian _____

Are There Any Substance Abuse Issues In The Household? YES NO

If "YES" Please Explain: _____

Health Habits

Do you exercise regularly? _____ If so, how often? _____ times per week / month

What type of exercising do you do? Please circle as applicable.

Walking Yoga Biking Pilates Swimming
Weight Training Martial Arts Home Exercise Video Aerobics

Do you eat a healthy balanced diet? _____

Are you currently trying to lose or gain weight? _____

If so, what is your diet plan? _____

Do you currently use any of the following? (o=occasionally / f=frequently /c=continuously)

____ Alcohol ____ Heroin ____ Cocaine ____ Marijuana
____ Barbiturates ____ Amphetamines ____ Ecstasy ____ Steroids

Have you used any of the above in the past? _____

Tobacco use: ____ Never ____ Former ____ Current every day ____ Current some days
_____ packs/day

Dip or Chew: ____ Never ____ Former ____ Current every day ____ Current some days

Caffeine Use ____ None ____ <3 drinks/day ____ 3-6 drinks/day ____ > 6 drinks/day

Family History

Please let us know if any family member has any health-related issues

Sibling (S) Father(F) Mother(M) Grandparent(G) Circle all that apply

Heart Disease S F M G Stroke S F M G Cancer S F M G

Diabetes S F M G High Blood Pressure S F M G Kidney Disease S F M G

Back/Neck Surgery S F M G Other _____

Reason For Visit

List one area of complaint per form. (ex. neck, back, arm, leg, headache are all separate areas)

Complaint/Problem

Please answer the following questions regarding the above listed complaint/problem

When does it feel WORSE? (circle all that apply)

No Change Morning As day progresses Afternoon Evening During the night

What makes it WORSE? (circle all that apply)

Nothing Resting Sleeping Walking Working Movement Using Computer Running Gym Driving Standing Sitting Recreational Activity Other

When does it feel BETTER?(circle all that apply)

No Change Morning As day progresses Afternoon Evening During the night

What makes it BETTER? (circle all that apply)

Nothing Cold Chiropractic Care Massage Movement Medication Resting Sleeping Walking Warmth

Please circle one or more items below which best describe your pain.

Achy Burning Dull Sharp Stiff Throbbing

Which best describes your pain?(circle one)

Mild Moderate Severe

What is your CURRENT pain level?

0 1 2 3 4 5 6 7 8 9 10 No pain Extreme pain

What is your pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10 No pain Extreme Pain

What is your pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10 No pain Extreme pain

Is the pain: (circle one)

Occasional Intermittent Frequent Constant

If the pain is not constant, how often does the pain occur?(circle all that apply)

0x 1x 2x 3x 4x 5x 6x 7x 8x 9x 10x per hour
0x 1x 2x 3x 4x 5x 6x 7x 8x 9x 10x per day
0x 1x 2x 3x 4x 5x 6x 7x 8x 9x 10x per week

Please fill out the following questions related to your complaint/problem

Does your pain radiate anywhere?
(circle one) (ex. Neck pain down arm)
Yes or No
If yes, where does it radiate to?

Are you experiencing any numbness?
(circle one)
Yes or No
If yes, where is it numb?

Are you having any muscle spasms?
(circle one)
Yes or No
If yes, where are the spasms?

Are you experiencing any weakness?
(circle one)
Yes or No
If yes, where is the weakness?

Do you have any swelling?
(circle one)
Yes or No
If yes, where is the swelling?

Are you noticing any decreased motion?
(circle one)
Yes or No
If yes, where is the decreased motion?

Is the pain worse when you move a certain way?
(circle one)
Yes or No
If yes, please explain what type of movement gives you pain.

How did this condition start?

When did this condition start?

Have you had prior pain in this area?

Which side is affected?

Is there anything else you think the doctor needs to know with regard to today's visit?

Patient Information

Please note: This information is needed in order to be compliant with the new Federal Guidelines for record keeping by providers.

Employment Information

Employer Name:

Employer Address:

Occupation:

Years at Occupation:

Emergency Contact Information

Contact Name:

Contact Phone:

Contact Address:

Advance Directives (Check): Living Will Durable Power Of Attorney Do not resuscitate
 No Living Will or Other

Confidential Communications Preference (Check all that apply): Home Phone Cell Phone
 Work Phone Email

by checking a preference, you are giving permission to King Chiropractic to call or e-mail you with upcoming appointments, billing information, medical information, etc

I consent to the evaluation and treatment for the care of my condition as determined necessary and provided by the doctor and staff of King Chiropractic of Florence. I authorize the release of all of my medical records to my referring and/or family physician and to the insurance carrier if applicable. I allow fax or e-mail transmittal of my medical records to those entitled to them. I authorize the release of any medical records from other providers including testing, MRI, CT, EMG, etc to King Chiropractic of Florence which have been discussed during evaluation or treatment, or determined necessary by the doctor at King Chiropractic of Florence regarding my health. I acknowledge full financial responsibility for services rendered by King Chiropractic of Florence. I understand that payment of charges is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs and interest in the event of default of payment of my charges. I further authorize that insurance payments be made to King Chiropractic of Florence should they elect to receive such payment. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. I consent to release previous medical records as related to my condition and determined necessary by King Chiropractic of Florence. This would include medical records from other medical providers, MRI center, diagnostic labs, or hospitals.

Our office is HIPAA compliant.

A copy of Notice of Privacy Practices is available upon request from the receptionist.

Patient Signature _____ Date _____