Kind-Ballard Chiropractic

Date:_____

Last Name:_____ First:_____ M:_____

Birthdate:_____/_____/_____ SS:_____/_____/_____

Address:_____

City:_____State:_____Zip:_____

Home: (_____)_____ Work: (_____)_____

Cell: (_____)_____

Email Address: _____

May we contact you via text? _____Yes _____No

May we leave a voicemail? _____Yes _____No

Employer:_____ Job Duties:_____

Marital Status: S___ M___ D___ W___ Sex: M__ F__

Who referred you to our office today?_____

Work Comp____ Auto____ Insurance____ Cash/Check/CC_____

Insurance Information - Please allow us to make a copy of your card(s)

Who is the primary insured?_____

Relationship to Patient?_____

Primary's Birthdate:_____/_____/_____ Primary's SS:_____/_____/_____

Where is the cardholder employed:_____

PATIENT CONDITION

Where is your pain today?_____

Rate your pain from 1(mild) to 10(severe) ***Please circle one***: 1 2 3 4 5 6 7 8 9 10

Is your pain: Constant_____ Frequent_____ Off/On_____ Occasional_____
Sharp_____ Dull_____ Ache _____ Numb_____ Tingling_____

How did your pain begin?_____

When did this latest episode begin?_____

What doctors have you seen for this condition? _____

What treatment have you had for this condition? _____

_____

Do you take any medication? _____

Vitamins?_____

What injuries/illnesses/surgeries have you had?_____

_____

Exercise: None___ Light___ Med___ Heavy___

Who is your family doctor?_____

May we notify him/her of your condition and treatment? Yes____ No____

How many *quality* hours of sleep do you get each night?_____