CONFIDENTIAL HEALTH INFORMATION

Herbert Kuehnemann, DC
The Natural Health Center, SC
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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.

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 ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Ethnicity

City

State/Province

ZIP/Postal Code

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 ◯ Work Phone ◯ Email

Primary Care Provider's Name

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

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

Patient name

Patient Number (office use only)

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?) ______

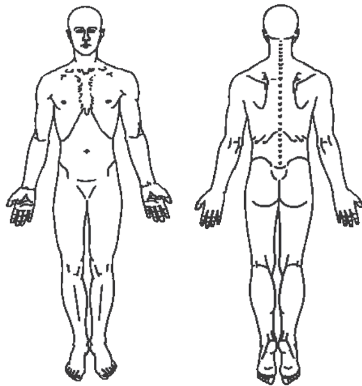
4. Intensity (How extreme are your current symptoms?)

Absent Uncomfortable Agonizing

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 ______

Consultation Notes

11. What else should Dr. Kuehnemann 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	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	NONE ◯
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	NONE ◯ Initials ____

c. Cardiovascular

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	NONE ◯ Initials ____

d. Respiratory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	NONE ◯ Initials ____

e. Digestive

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	NONE ◯ Initials ____

f. Sensory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	NONE ◯ Initials ____

g. Skin

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	NONE ◯ Initials ____

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h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	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.

PERSONAL

14. Illnesses
Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	Sexually transmitted disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer
○	○	Other: ____________

17. Allergies
Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ____________

15. Operations
Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____________
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____________
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____________

16. Treatments
Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): ____________

18. Injuries
Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

19. Family History
Some health issues are hereditary. Tell Dr. Kuehnemann about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	Poor	Illnesses	Age at death	Cause of death: Natural	Illness
Mother	____	○	○	____	____	○	○
Father	____	○	○	____	____	○	○
Sister 1	____	○	○	____	____	○	○
Sister 2	____	○	○	____	____	○	○
Brother 1	____	○	○	____	____	○	○
Brother 2	____	○	○	____	____	○	○
____	____	○	○	____	____	○	○

20. Are there any other hereditary health issues that you know about? ____________

21. Social History
Tell Dr. Kuehnemann about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? ____
Coffee use	○ Daily	○ Weekly	How much? ____
Tobacco use	○ Daily	○ Weekly	How much? ____
Exercising	○ Daily	○ Weekly	How much? ____
Pain relievers	○ Daily	○ Weekly	How much? ____
Soft drinks	○ Daily	○ Weekly	How much? ____
Water intake	○ Daily	○ Weekly	How much? ____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Hobbies: ____________

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22. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

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) ______________________

Patient name

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