DR. TRICIA KAMERER
CHIROPRACTIC PHYSICIAN
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Patient Name: ______________________________ **Date:** ____________________

Address______________________________**City**____________ **State** ________**Zip Code** ________

H. Phone ____________________**W. Phone**____________________**Cell Phone** ____________________

Email Address: ______________________________ **Sex M F Marital Status M S D W P**

Date of Birth__________**Age**______**Emergency Contact**____________________**Phone Number**__________

Do you want to receive automated appointment reminders? Text Email **Occupation**____________________

Employer____________________**Employer Address**______________________________

Spouse Name ____________________**Phone Number**______________________________

Spouse Employer______________________________ **Address**______________________________

Referred by: ______________________________

Have you ever received Chiropractic Care? Yes No If yes, when? ____________________

Name of most recent Chiropractor: ______________________________

1. Reasons for seeking chiropractic care:

Primary reason: ____________________Secondary reason: ____________________

Is the reason due to an injury related to: Work Accident Auto Accident Other Accident Explain__________

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____
____
____

3. Past Health History: Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	**Yes**	**No**	**Diabetes**	**Yes**	**No**	**Liver Disease**	**Yes**	**No**	**Rheumatic Fever**	**Yes**	**No**
Alcoholism	**Yes**	**No**	**Emphysema**	**Yes**	**No**	**Measles**	**Yes**	**No**	**Scarlet Fever**	**Yes**	**No**
Allergy Shots	**Yes**	**No**	**Epilepsy**	**Yes**	**No**	**Migraine**	**Yes**	**No**	**Sexually Transmitted Disease**	**Yes**	**No**
Anemia	**Yes**	**No**	**Fractures**	**Yes**	**No**	**Miscarriage**	**Yes**	**No**			
Anorexia	**Yes**	**No**	**Glaucoma**	**Yes**	**No**	**Multiple Sclerosis**	**Yes**	**No**	**Stroke**	**Yes**	**No**
Appendicitis	**Yes**	**No**	**Goiter**	**Yes**	**No**	**Mumps**	**Yes**	**No**	**Suicide Attempt**	**Yes**	**No**
Arthritis	**Yes**	**No**	**Gonorrhea**	**Yes**	**No**	**Osteoporosis**	**Yes**	**No**	**Thyroid Problems**	**Yes**	**No**
Asthma	**Yes**	**No**	**Gout**	**Yes**	**No**	**Pacemaker**	**Yes**	**No**	**Tonsillitis**	**Yes**	**No**
Bleeding Disorders	**Yes**	**No**	**Heart Disease**	**Yes**	**No**	**Parkinson's Disease**	**Yes**	**No**	**Tuberculosis**	**Yes**	**No**
Breast Lump	**Yes**	**No**	**Hepatitis**	**Yes**	**No**	**Pinched Nerve**	**Yes**	**No**	**Typhoid Fever**	**Yes**	**No**
Bronchitis	**Yes**	**No**	**Hernia**	**Yes**	**No**	**Pneumonia**	**Yes**	**No**	**Ulcers**	**Yes**	**No**
Bulimia	**Yes**	**No**	**Herniated Disk**	**Yes**	**No**	**Polio**	**Yes**	**No**	**Vaginal Infections**	**Yes**	**No**
Cancer	**Yes**	**No**	**Herpes**	**Yes**	**No**	**Prostate Problem**	**Yes**	**No**	**Whooping Cough**	**Yes**	**No**
Cataracts	**Yes**	**No**	**High Blood Pressure**	**Yes**	**No**	**Prosthesis**	**Yes**	**No**	**Other**__________		
Chemical Dependency	**Yes**	**No**	**High Cholesterol**	**Yes**	**No**	**Psychiatric Care**	**Yes**	**No**	__________		
Chicken Pox	**Yes**	**No**	**Kidney Disease**	**Yes**	**No**	**Rheumatoid Arthritis**	**Yes**	**No**	__________		

Patient Name: ______________________________ **Date:** ____________________

Medication: **Reason For Taking:**

____

____

____

____

4. **Allergies: Please list all known allergies.**

____

____

Injuries/Surgeries: Description Date

Falls ______________________________ ____________

Head Injuries ______________________________ ____________

Broken Bones ______________________________ ____________

Dislocations ______________________________ ____________

Surgeries ______________________________ ____________

Females/ Pregnancies

Are you pregnant? Yes No When are you due?____________ How many pregnancies? ____________

5. **Family Health History: Do either of your parents or other relatives have any of the following? If yes, who?**

Arthritis	**Yes**	**No Who?**________	**Diabetes**	**Yes**	**No Who?**________	**Kidney Disease**	**Yes**	**No Who?**________
Asthma	**Yes**	**No Who?**________	**Heart Disease**	**Yes**	**No Who?**________	**Lung Disease**	**Yes**	**No Who?**________
Cancer	**Yes**	**No Who?**________	**High Blood Pressure**	**Yes**	**No Who?**________	**Mental Health**	**Yes**	**No Who?**________

Is your mother still living? Yes No Age________ **Condition of Health**______________________________

Is your father still living? Yes No Age________ **Condition of Health**______________________________

6. **Social and Occupational History:**

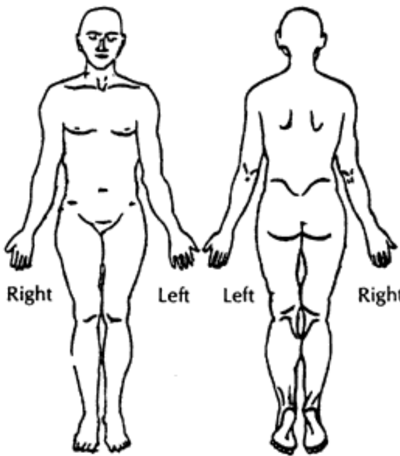
Exercise	**Work Activity**	**Habits**		**Sleeping Habits**
None	Sitting	Smoking	Packs/Day________	Side Sleeper
Moderate	Standing	Alcohol	Drinks/Week________	Back Sleeper
Daily	Light Labor	Coffee/Caffeine	Cups/Day________	Stomach Sleeper
Heavy	Heavy Labor	Recreational Drugs	What?/Day________	How many pillows:
		Water	Cups/Day________	________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Patricia Kamerer, D.C.** for services performed.

Patient or Guardian Signature ______________________________ Date________________

Patient Name: ____Date: _____________________________________

7. **Please mark on the drawing your areas of complaint:**



8. **Please answer the following questions about your symptoms:**

Symptom 1 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: ____ **Date:** ______________________________________

Symptom 2 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? How did the symptom begin? ________________________
- What makes the symptom worse? (circle all that apply):

  Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other: _______________________
- Does the symptom radiate to another part of your body (circle one): yes no If yes, Where? ___________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? How did the symptom begin? ________________________
- What makes the symptom worse? (circle all that apply):

  Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other: _______________________
- Does the symptom radiate to another part of your body (circle one): yes no If yes, where? ___________________
- Is the symptom worse at certain times of the day? Morning Afternoon Evening Night Unaffected by time of day