521 Yopp Rd. Ste 107, Jacksonville, NC 28540
910-333-9723
www.KeeferChiropractic.com

Pt #:

Patient Name: (last) _____ (first) _____ (MI) ____ Patient DOB:_____
Age:____ Male/Female SS#_____ Driver's License #:_____ Issue State:_____
Home Address: _____(city)_____(zip)_____
Mailing Address:_____(city)_____(zip)_____
Phone: (home)_____ (work)_____ (Cell)_____
Occupation: _____ Employer:_____
Single/Married/Widowed/Divorced Spouse's Name:_____ Spouse's DOB:_____
How many children do you have? _____ How did you hear about our office? _____
Email Address:_____ Who is your family Dr.?_____
Emergency Contact:_____ Contact Phone: _____ Relationship:_____

What brings you to the office today? (Chief complaints) Please rate each condition on a scale of 1-10, 10 being severe pain, 1 being no pain. After you rate each symptom on a scale of 1-10, put the date that you first noticed the symptom on the line next to the pain rating.

Ex-____Neck Pain_____ (7 /10) _1-12-13
(Onset Date)

1-_____(/10)_____
(Onset Date)

2-_____(/10)_____
(Onset Date)

3-_____(/10)_____
(Onset Date)

4-_____(/10)_____
(Onset Date)

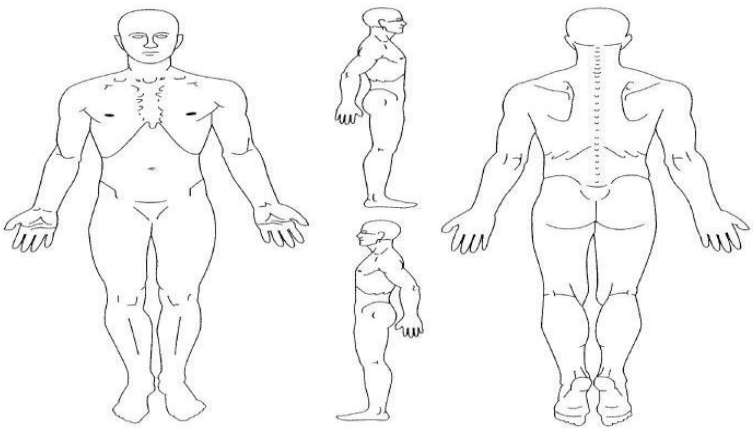
5-_____(/10)_____
(Onset Date)

6-_____(/10)_____
(Onset Date)

7-_____(/10)_____
(Onset Date)

What caused your condition/s? _____

Please indicate on the diagram that follows where you are having your pain. Use the key provided to indicate the type of pain you are having.



S	Sharp
Sh	Shooting
B	Burning
St	Stabbing
T	Tingling
N	Numbing
I	Itching

Dr. Use Only	
Height	
Weight	
B/P	
HR	

1-Are any of your conditions a result of: A Motor Vehicle Accident_____ A Work Related Injury_____

2-Have you had any treatment for your condition/s? No___ Yes(explain)_____

_____

3-Are the symptoms getting: Better_____ Worse_____Staying the Same_____

4-How often are you experiencing your symptoms?

Constantly (76-100%)_____ Frequently (51-75%)_____ Occasionally (26-50%)_____ Intermittently (0-25%)____

5-Have you had similar symptoms in the past? No ___ Yes (explain)_____

6-List any surgeries:_____

7-List any medications (prescription or over the counter)? _____

_____

8-List any accidents, injuries or traumas in your past? _____

_____

9-List all medical conditions that you have: _____

_____

10-Check all that you use/do: Caffeine _____ Alcohol_____ Cigarettes _____ Chew Tobacco____ Exercise _____

Other:_____

11-Do you have any allergies: No ____ Yes (explain) _____

12-List all medical conditions of your immediate family (mother, father, siblings): _____

_____

Occupational Activities: (Please indicate the items that describe your job/daily activities the best)					
Administration		Child Care		Construction	
Business Owner		Home Services		Heavy Manual Labor	
Clerical/Secretarial		Food Services		Medium Manual Labor	
Computer Use		Executive/Legal		Light Manual Labor	
Health Care		Manufacturing		Other:	

_____

Consent to Treat

I consent to the treatment, examinations and therapies provided to me by Keefer Chiropractic. I have been given a copy of the **informed consent** and have been given the opportunity to ask questions and have those questions answered. I also acknowledge that the information that I have given on this form is true and correct to the best of my knowledge.

Hipaa Notification

By signing below I acknowledge that I have been given a copy of the office's full **HIPAA Notification** to read and review. I have been given the opportunity to ask any questions and have those questions answered.

Consent to Treat a Minor

By signing below, I give permission to the staff and doctors at Keefer Chiropractic to treat my child or child that I am legally responsible for.

Parent/Legal guardian's consent to treat a Minor: (Minor printed name)_____

Guardian Signature Authorizing Care: _____ Date:_____

Patient Name: _____Pt Signature: _____Date: _____

Doctor Signature: _____ Date: _____

Keefer CHIROPRACTIC Trusted Care
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Patient Name: _____ Date: _____

Please review all of the following conditions. If you have any of the conditions currently, check (present). If you have had any conditions in the past, check (past). Circle (None) if you have had no conditions in that system.

Cardiovascular	None		**Respiratory**	None		**Allergic/Immunologic**	None	
	Past	Present		Past	Present		Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Embolism			Emphysema			Allergy Shots		
Heart Disease			Severe Cold/Flu			Cortisone Use		
Heart Attack			Unusual Cough					
Chest Pain			Wheezing			**Ear, Nose, Throat**	None	
High Cholesterol							Past	Present
Pace Maker			**Eyes**	None		Difficulty Swallowing		
Jaw Pain				Past	Present	Dizziness		
Irregular Heartbeat			Glaucoma			Hearing Loss		
Swelling of Legs			Double Vision			Sore Throat		
			Blurred Vision			Nosebleeds		
Genitourinary	None					Bleeding Gums		
	Past	Present	**Psychiatric**	None		Sinus Infections		
Kidney Disease				Past	Present			
Burning Urination			Depression			**Gastrointestinal**	None	
Frequent Urination			Anxiety				Past	Present
Blood in Urine			Stress			Gall Bladder Problems		
Kidney Stones						Bowel Problems		
Lower Side Pain			**Endocrine**	None		Constipation		
				Past	Present	Liver Problems		
Neurologic	None		Hypothyroidism			Ulcers		
	Past	Present	Hyperthyroidism			Diarrhea		
Stroke			Diabetes			Nausea/Vomiting		
Seizures			Hair Loss			Bloody Stools		
Head Injury			Menopausal			Poor Appetite		
Brain Aneurysm			Menstral Complications					
Numbness						**Musculoskeletal**	None	
Severe Headaches			**Hematologic**	None			Past	Present
Pinched Nerves				Past	Present	Gout		
Parkinson's			Hepatitis			Arthritis		
Carpal Tunnel			Blood Clots			Joint Stiffness		
Vertigo			Cancer			Muscle Weakness		
Ringing in ears			Easily Bruised			Osteoporosis		
			Bleeding			Broken Bones		
Constitutional	None		Fever, Chills			Joint Replacements		
	Past	Present	Sweating					
Weight Loss/Gain						Are you Pregnant?	No	Yes
Low Energy Level						Could you be Pregnant?	No	Yes
Difficulty Sleeping						List any other conditions you have that were not listed:		

Patient Signature:_____ Date:_____ Dr. Int: _____