Keefer CHIROPRACTIC
Trusted Care

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

Patient Name: (last)_____ (first)_____(MI) _____ Pt DOB: _____

Age:_____ Male/Female SS#: _____ Driver's License #:_____ State Issued: _____

Home Address: _____ (city/state) _____ (zip) _____

Mailing Address: _____ (city/state) _____ (zip) _____

Phone: (home) _____ (work) _____ (cell) _____

Number of Children: _____ Occupation: _____ Employer:_____

Single/Married/Widowed/Divorced Spouse Name: _____ Spouse DOB: _____

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=severe pain / 1=no pain) On the line beside each condition, put the date of onset and best-known cause. You may also say unknown.

EX: Neck Pain (7 /10) 1-12-19
(onset date)

1- _____ (/10) _____
(onset date)

2- _____ (/10) _____
(onset date)

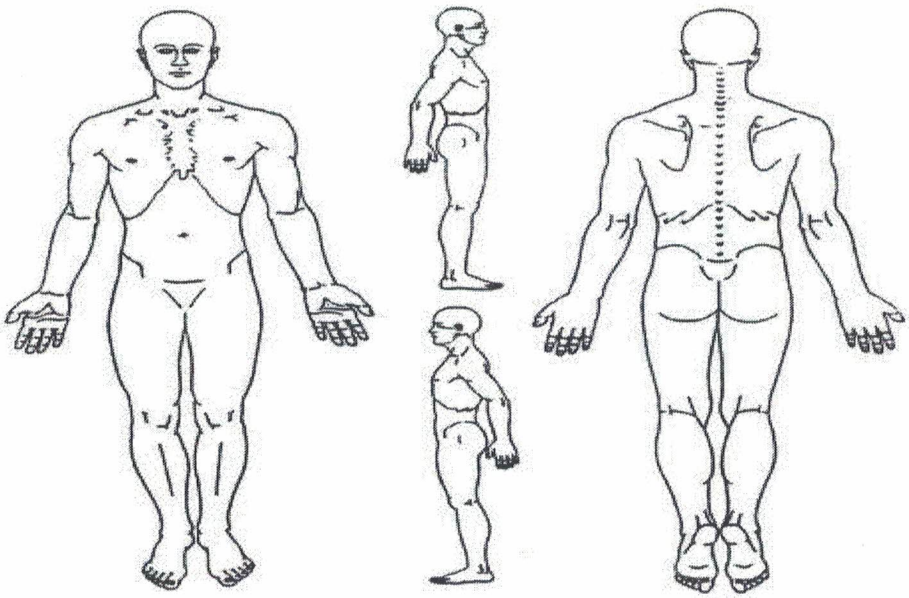
3- _____ (/10) _____
(onset date)

4- _____ (/10) _____
(onset date)

5- _____ (/10) _____
(onset date)

What caused your condition/s?: _____

Please indicate on the diagram below where you are having pain. Use the key provided to help describe the pain.



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

Dr. Use Only

Height	
Weight	
B/P	
HR	

Are any of your conditions a result of: A Motor Vehicle Accident: _____ A Work Related Injury: _____

Have you had any kind of treatment for your conditions: No: _____ Yes: (explain) _____

_____

Are your conditions getting: Better: _____ Worse: _____ Staying Same: _____

Do you have your symptoms: Constantly (75-100%) ___ Frequently (51-74%) ___ Occasionally (26-50%) ___ Comes and goes (0-25%) ____

Have you experienced your symptoms in the past: No____ Yes (explain) _____

List all surgeries: _____

List any medications: _____

List all medical conditions: _____

List any past injuries or traumas: _____

Do you use/consume: Caffeine ___ Alcohol ___ Cigarettes ___ Tobacco (chew) ___ Other drugs: _____

Do you exercise? No___ Yes ___ How often? _____ What type: _____

Do you have any known chemical or medication allergies? No ___ Yes (list) _____

List all medical conditions of immediate family members (Mother, Father, Siblings): _____

_____

What do your daily activities consist of? (Check below if applicable.)

Administrative work		Food Service		Medium Manual Labor	Other: (list below)
Computer use		Manufacturing work		Light Manual Labor	
Health Care work		Construction		Repetitive Movements	
Child Care		Heavy Manual Labor		Bending/ Lifting	

Can you think of anything else we should know about you? _____

If patient is a minor: The person signing this document must be a parent or legal guardian and must be present for care. By signing below, Parent/Legal guardian consents to the treatment of the minor on this intake by the staff of Keefer Chiropractic.

Parent/Legal guardian signature authorizing care: _____ Date: _____

For patients who are 18 years old or older, for the legal guardians of minors:
By signing below:

You give permission for the staff of Keefer Chiropractic to provide treatment to you or your child for listed conditions.
You acknowledge you have been provided with a full copy of our Hipaa Notifications to review.
You acknowledge you have been given an informed consent to review prior to treatment and have been given to opportunity to ask questions in relation to your treatment.
You confirm that the information above is complete and accurate to the best of your knowledge.

Patient Name: (print) _____ **Signature:** _____ **Date:** _____

Doctor Signature: _____ Date: _____

Keefer CHIROPRACTIC Trusted Care

521 Yopp Rd. Ste 107, Jacksonville, NC 28540
P: 910-333-9723 F: 910-333-8454

PLEASE MARK PAST OR PRESENT IF YOU HAVE HAD THE CONDITION MENTIONED. LEAVE BLANK IF YOU HAVE NOT HAD CONDITION AT ALL.

Constitutional	Past	Pres	Eyes	Past	Pres	Cardiovascular	Past	Pres	Respiratory	Past	Pres
Chills			Blindness			Angina			Asthma		
Drowsiness			Blurred Vision			Chest Pain			Bronchitis (chronic)		
Fainting			Cataracts			Claudication			Dry Cough		
Fatigue			Change in Vision			Heart Murmur			Productive Cough		
Fever			Double Vision			Heart Problems			Coughing up Blood		
Night Sweats			Dry Eyes			High Blood Pressure			Difficulty Breathing		
Weakness			Eye Pain			Low Blood Pressure			Difficulty Sleeping		
Weight Gain			Field Cuts			Orthopnea			Hemoptysis		
Weight Loss			Glaucoma			Palpitations			Pneumonia		
			Sensitivity to Light			Shortness of Breath			Sputum Production		
			Tearing			Swelling of Legs			Wheezing		
			Wears Glasses			Varicose Veins					
Musculoskeletal			**Integumentary**			**EMNT**					
Arthritis			Breast Lumps/Pain			Bad Breath			Nasal Congestion		
Neck Pain			Change in Nail Texture			Dentures			Nose Bleeds		
Decreased Motion			Change in Skin Color			Deviated Septum			Post Nasal Drip		
Gout			Eczema			Difficulty Swallowing			Sinus Infections		
Past Injuries			Hair Growth			Discharge			Runny Nose		
Joint Pain			Hair Loss			Dry Mouth			Snoring		
Joint Stiffness			Skin Disorders			Ear Drainage			Sore Throat		
Locking Joints			Hives			Ear Pain			Ringing in Ears		
Back Pain			Itching			Frequent Sore Throat			TMJ Problems		
Muscle Cramps			Paresthesia			Head Injury			Ulcers		
Muscle Pain			Rash			Hearing Loss					
Muscle Twitching			Skin Lesions			Hoarseness					
Muscle Weakness						Loss of Smell					
Swelling						Loss of Taste					
Gastrointestinal			**Genitourinary**			**Neurological**			**Psychiatric**		
Abdominal Pain			Birth Control			Change in concentration			Agitation		
Belching			Burning Urination			Change in Memory			Anxiety		
Black,Tarry Stools			Cramps			Dizziness			Appetite Change		
Constipation			Erectile Dysfunction			Headache			Behavioral Changes		
Diarrhea			Frequent Urination			Imbalance			Bipolar		
Heartburn			Hesitancy/Dribbling			Loss of Consciousness			Confusion		
Hemorrhoids			Hormone Therapy			Loss of Memory			Convulsions		
Indigestion			Irregular Menstration			Numbness			Depression		
Jaundice			Bladder Control			Seizures			Insomnia		
Nausea			Prostate Problems			Sleep Troubles			Disorientation		
Rectal Bleeding			Urine Retention			Slurred Speech			Memory Loss		
Abnormal Stool			Vaginal Bleeding			Stress			Substance Abuse		
Vomittiing			Vaginal Discharge			Strokes					
						Tremors			Female: Pregnant? Yes or No		
Endocrine			**Blood/lymphatic**			**Immunology**					
Diabetes			Anemia			History of Anaphylaxis					
Excessive Appetite			Bleeding			Itchy Eyes					
Excessive Thirst			Blood Clotting			Sneezing			Other:		
Goiter			Blood Transfusion			Food Sensitivity					
Hair Loss			Bruise Easily								
Heat Intolerance			Lymph Node Swelling								
Unusual Hair Growth											
Voice Changes											

Print Name: _____ Sign: _____ Date: _____ Dr. Int: _____

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Employment, ADL, and Recreation Information (taken from HNS website)

Patient name _____ File # _____ Date _____

Daily Activities: Please indicate how your conditions affect the following activities. Mild means you can fully perform the activity, but you experience pain. Moderate (Mod) means you can partially perform the activity and are limited due to pain. Severe means you cannot perform the activity at all.

Bending (lower back):	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Bending (mid back):	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Bending (neck):	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Carrying Groceries:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐Severe (Unable to Perform)
Change Posn–Sit-Stand:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Climb Stairs:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Driving:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Extended Computer Use:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Bringing Food to Mouth:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Household Chores:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Kneeling:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Lifting Children:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Lifting Objects:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Pet Care:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Reading (concentration):	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Self Care–Bathing:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Self Care–Dressing:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Self Care–Shaving:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Sexual Activities:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Sleeping:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Sitting Still:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Standing Still:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Walking:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)
Yard Work:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe** (Unable to Perform)

Any other motions or activities you have tried which have been affected:

_____	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (limited)	☐**Severe** (Unable to Perform)
_____	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (limited)	☐**Severe** (Unable to Perform)
_____	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (limited)	☐**Severe** (Unable to Perform)

Patient Signature _____ Date _____

Attending Doctor's Signature _____ Date _____