KOKOMO CHIROPRACTIC, PC
824 BELVEDERE DR.
KOKOMO, IN 46901

NAME: ______________________________ **DATE:** _________________________

Purpose of this appointment: ____

C/C: Describe your present complaints: ____

O: Date it occurred? ___________ How did your condition occur? __________________________

P/P: What makes your condition better?____________________ Worse?____________________

Q: Pain? **sharp** / **dull** / **ache** / **stabbing** / **shooting**

R: Radiating Pain? **Rt** / **Lt** arm **Rt** / **Lt** leg **NONE**

T: Frequency of pain? **every day** / **every 3rd day** / **once a wk** / **other**_________________

S: Duration of pain? **constant pain** / **on & off pain**

Time of day? **morning** / **afternoon** / **evening** / **all times**

PN LEVEL: (mild pain) **1 2 3 4 5 6 7 8 9 10** (severe pain)

Have you had any problems with…

Eyes/ears/nose/throat? ______________________ Respiratory? ______________________
Heart? ______________________ High blood pressure? ______________________
G.I.? ______________________ Urinary? ______________________
Nervous system? ______________________ Bones? ______________________
Blood? ______________________ Diabetes? ______________________
Cancer? ______________________

Have you had any major illnesses, surgeries, or accidents? **YES** / **NO** if yes, what and when?

____

____

Are you currently pregnant? **YES** / **NO**

**By signing this document you are agreeing the Dr. Hicks and Kokomo Chiropractic, PC will not be held responsible for complications that would be related from x-rays in the event of pregnancy.*

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Have you seen any other doctor for this condition? **YES** / **NO** If yes, who?____________________

Have you been treated for any other health condition in the past year? **YES** / **NO**

If yes, please describe:____

If you are over the age of 13, do you currently smoke? **YES** / **NO**

FAMILY HX: **Biological Parents**

High Blood Pressure? **Mom** / **Dad** Cancer? ___________________**Mom** / **Dad**
Diabetes? **Mom** / **Dad** Other? ___________________ **Mom** / **Dad**

MEDS: List any medication you are taking at this time. (birth control, painkillers, insulin, etc.)
____

Please list any medications that you are allergic to: ____

Have you consulted a Chiropractor in the past? **YES** / **NO** If yes, who?________________________

How Did You Hear Of Us? **Phone Book** **Friend:** ____________________________________

Doctor: _______________________________ **Other:** ____________________________________

FEES ARE PAYABLE AT THE TIME OF SERVICE

The above information is true to the best of my knowledge. I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, chiropractic care or any clinic services that he deems necessary in my case. (X-rays remain property of Kokomo Chiropractic, PC.) I understand that chiropractic does not diagnose nor treat disease. Chiropractic has only one goal: to locate, analyze and correct spinal interference to the nervous system. I understand that if proper paperwork is provided, my insurance will be billed. I authorize my insurance benefits to be paid to Kokomo Chiropractic, PC. I understand that I am financially responsible for any balance. If my account becomes 60 days past due my account will be sent to a collections resource. I agree to also pay for all costs of collections, including, but not limited to: interest charges, collection agency fees, and legal cost and attorney fees. I also authorize Kokomo Chiropractic, PC or my insurance company to release any information required to process claims. I permit a copy of this original to be used in place of all previously signed documents with Kokomo Chiropractic, PC.

PATIENT'S SIGNATURE ___________________________________ DATE__________________
If patient is a minor, parent or guardian must sign.

WITNESS SIGNATURE ___________________________________ DATE__________________