ABOUT THE PATIENT

Kuns Chiropractic Clinic 405 NE Division St. Gresham Or 97030 503-661-0791 Kuns@Kunschiropractic.com

Name ______________________________ Today's Date__________ Birthdate __________ Age________

Address ______________________________ City ____________________ State ______ Zip __________

Home Phone ________________ Cell Phone ________________ Work Phone ________________Gender ❑ M ❑ F

Significant Other's Name ________________________ Who referred you to us ____________________________

Your Employer ____________________________ Type of Work ________________________________

e-Mail Address ______________________________________ Have you been to a chiropractor before? ▫ No ▫ Yes

Emergency Contact ________________________________ ph # ______________________________

Name of Medical Doctor(s)____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Kuns Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_________________________
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

____ ______________________

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. ____ How long has this been an issue? ______
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to____________________
2. ____ How long has this been an issue? ______
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to____________________
3. ____ How long has this been an issue? ______
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to____________________
4. ____ How long has this been an issue? ______
   Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to__________________
5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
6. What makes it better?____
7. What makes it worse? ____
8. What Doctor's have you seen for this?______________________________
   ____
9. Type of treatment:____
10. Results: ____

Rate your pain on a scale of 1 (best) to 10 (worst)

1 2 3 4 5 6 7 8 9 10

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.