Cascade Chiropractic Clinic, P.C.
Dr. Mark Kline
6151 28th Street, SE
Grand Rapids, MI 49546

Patient Information

Patient Information

NAME:_____ DATE:_____

NICKNAME (HOW WOULD YOU LIKE US TO REFER TO YOU?) _____

DATE OF BIRTH:_____ YOUR SS#:_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PH:_____ WOULD PREFER: HOME___ WORK___ CELL___

E-MAIL ADDRESS: _____

WHERE ARE YOU EMPLOYED?_____

MARRIED___ SINGLE___ WIDOWED___ DIVORCED___ SEPARATED___

SPOUSE'S NAME_____

SPOUSE'S EMPLOYER_____

HOW WERE YOU REFERRED TO THIS OFFICE?_____

RESPONSIBLE FOR CHARGES AT THIS OFFICE: SELF_____SPOUSE_____

PARENT_____ OTHER _____

IS HEALTH INSURANCE INVOLVED? YES____NO____UNSURE____

HEALTH INSURANCE COMPANY_____

MEMBER ID# _____GROUP# _____INSURED_____

RELATIONSHIP TO INSURED: SELF____SPOUSE____CHILD____OTHER___

INSURED'S SS#_____INSURED'S BIRTH DATE_____

OTHER INSURANCE: YES____NO____

IS YOUR CONDITION RELATED TO AN AUTOMOBILE ACCIDENT? YES____NO___

IS YOUR CONDITION A WORK RELATED INJURY? YES____NO____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS, AND TREATMENTS ARE RENDERED, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF CASCADE CHIRORACTIC CLINIC, P.C.. I AUTHORIZE TREATMENT BY DR. MARK KLINE AND AGREE TO THE RELEASE OF INFORMATION NECESSARY FOR MY TREATMENT OR FOR THE PROCESSING OF INSURANCE CLAIMS.

PATIENT'S SIGNATURE: _____ DATE:_____
(PARENT OR GUARDIAN IF A MINOR)

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Health Information

Health Information

1) NAME:_____ 2) DATE:_____

3) MAJOR COMPLAINTS:_____

_____

_____

_____

_____

4) HOW DID THIS CONDITION DEVELOP? _____

_____

5) WHEN DID THIS START?_____

6) HAVE YOU EVER HAD THIS BEFORE? Y __ N __ WHEN? _____

7) THIS HAS BEEN GETTING: BETTER _____% WORSE _____% SAME _____

8) HAVE YOU BEEN SEEN OR TREATED FOR THIS? Y __ N __ HERE? Y __ N __

WHERE? _____

9) WHAT HAVE YOU DONE TO TRY TO RELIEVE THE SYMPTOMS? _____

_____

10) WHAT MAKES THE SYMPTOM(S) WORSE? _____

_____

11) WHAT NORMAL ACTIVITIES HAVE YOU CHANGED SINCE THIS STARTED? _____

_____

12) HAVE YOU HAD ANY ACCIDENTS OR INJURIES (AUTO OR OTHER)? Y __ N __

IF YES DESCRIBE: _____

_____

_____

13) LIST ANY MEDICATIONS YOU ARE TAKING: _____

_____

_____

14) SURGERIES (WHEN): _____

_____

_____

15) HAVE YOU EVER RECEIVED CHIROPRACTIC CARE BEFORE? Y __ N __ WHEN? _____

16) COMMENTS: _____

(Rev. 04-03-12)

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

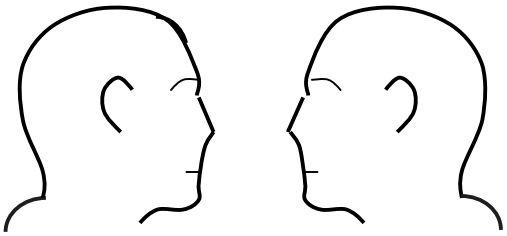
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

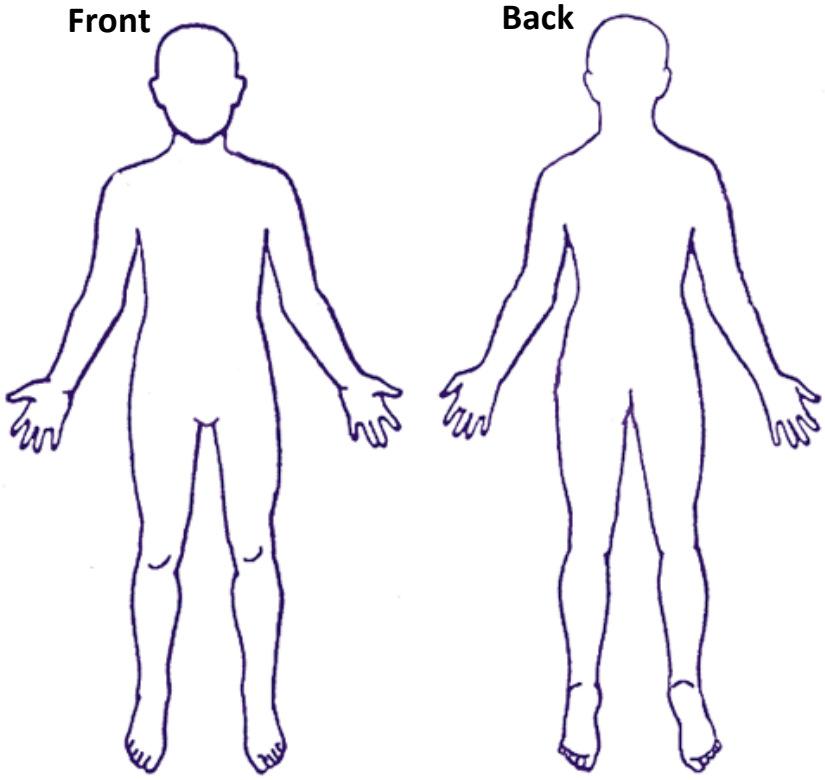
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A = Ache
B = Burning
ST = Stabbing
SP = Spasm
N = Numbness
P = Pins and Needles
T = Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**