Karminski Chiropractic
Natural Health and Wellness

Today's Date: _____

PATIENT INFORMATION SHEET

Name: First_____ MI _____ Last_____

Street Address: _____

City:_____ State:_____Zip Code_____

E-Mail:_____ Home Phone:_____

Date of Birth: _____ Cell Phone:_____

Illness Date:_____ Accident Date:_____

Date Consulted for this Condition:_____

Marital Status: M/S/D/W/SEP_____ Occupation:_____

Employer:_____

Employer Street Address: _____

City:_____ State:_____Zip Code_____

Work Phone:_____ Work Email:_____

Who referred you to this office?_____

Initial Complaint and Duration:_____

X-ray date/where taken_____

Insurance Information:

First Insurance Company: _____

Street Address:_____

City:_____ State:_____Zip Code_____

Phone Number:_____ Fax Number:_____

Karminski Chiropractic
Natural Health and Wellness

Adjuster: _____

Payor ID Number:_____Policy Number:_____

Claim Number:_____Grp/Plan Number:_____

Plan or Program Name:_____

Policy Holder Information:

Name: First_____ MI _____ Last_____

Street Address: _____

City:_____ State:_____Zip Code_____

Phone Number:_____ Insured ID No._____

Insured Date of Birth: _____

Relationship to patient: Self/Spouse/Parent _____

Insured's Employer or School: _____

Second Insurance Information:

First Insurance Company: _____

Street Address:_____

City:_____ State:_____Zip Code_____

Phone Number:_____ Fax Number:_____

Adjuster: _____

Payor ID Number:_____Policy Number:_____

Claim Number:_____Grp/Plan Number:_____

Plan or Program Name:_____

Karminski Chiropractic
Natural Health and Wellness

Secondary Policy Holder Information:

Name: First_____ MI _____ Last_____

Street Address: _____

City:_____ State:_____Zip Code_____

Phone Number:_____ Insured ID No._____

Insured Date of Birth: _____

Relationship to patient: Self/Spouse/Parent _____

Insured's Employer or School: _____

Attorney Information:

Name:_____

Firm Name:_____

Street Address: _____

City:_____ State:_____Zip Code_____

Phone Number:_____ Fax Number:_____

Karminski Chiropractic
Natural Health and Wellness

Today's Date: _____

PATIENT BASIC INFORMATION

Name: First_____ MI _____ Last_____

Date of Injury/Onset:_____ Dominant Hand: Left / Right / Both

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury, or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Karminski Chiropractic
Natural Health and Wellness

Today's Date: _____

Patient Name:_____

Description of Symptoms: (Describe symptoms below, in the order of severity if possible)

First Current Symptom (Describe only ONE symptom per section)

1. Check on location below

□Headaches □L □R □B
Part of head:
□Front □Top □ Back
□Jaw □L □R □B
□Eye □L □R □B
□Neck □L □R □B
□Upper Back □L □R □B
□Mid Back □L □R □B
□Low Back □L □R □B
□Chest □L □R □B
□Abdomen □L □R □B
□Ribs □L □R □B
□Buttocks □L □R □B
□Shoulder □L □R □B
□Upper Arm □L □R □B
□Forearm □L □R □B
□Hand □L □R □B
□Hip □L □R □B
□Leg □L □R □B
□Foot □L □R □B
□Other Locations:_____
_____

2. Types of Pain:

□Dull □Sharp □Aching □Cutting
□Throbbing □Burning □Numbing □Tingling □Cramping
□Spasm □Stinging □Shooting □Pounding □Constricting
Other:_____

3. Pain Frequency

□¼ of awake time □¼ to ½ time
□½ to ¾ time □Most all the time

4. Pain Intensity: How does it affect your daily activities?

□Doesn't Affect □Somewhat Affects
□Seriously Affects □Prevents Activity

5. Does this pain radiate into other body parts?

Head □L □R □B
Neck □L □R □B
Shoulder □L □R □B
Arm □L □R □B
Hand □L □R □B
Hip □L □R □B
Leg □L □R □B
Foot □L □R □B
Other:_____

6. Actions affecting this pain

Brings On/Aggravates/Relieves

□In the A.M. □ □ □
□In the P.M. □ □ □
□Bend forward □ □ □
□Bend back □ □ □
□Bend left □ □ □
□Bend right □ □ □
□Twist left □ □ □
□Twist right □ □ □
□Coughing □ □ □
□Sneezing □ □ □
□Straining □ □ □
□Standing □ □ □
□Sitting □ □ □
□Lifting □ □ □
Other: _____
_____

Second Current Symptom (Describe only ONE symptom per section)

1. Check on location below

□Headaches □L □R □B
Part of head:
□Front □Top □ Back
□Jaw □L □R □B
□Eye □L □R □B
□Neck □L □R □B
□Upper Back □L □R □B
□Mid Back □L □R □B
□Low Back □L □R □B
□Chest □L □R □B
□Abdomen □L □R □B
□Ribs □L □R □B
□Buttocks □L □R □B
□Shoulder □L □R □B
□Upper Arm □L □R □B
□Forearm □L □R □B
□Hand □L □R □B
□Hip □L □R □B
□Leg □L □R □B
□Foot □L □R □B
□Other Locations:_____
_____

2. Types of Pain:

□Dull □Sharp □Aching □Cutting
□Throbbing □Burning □Numbing □Tingling □Cramping
□Spasm □Stinging □Shooting □Pounding □Constricting
Other:_____

3. Pain Frequency

□¼ of awake time □¼ to ½ time
□½ to ¾ time □Most all the time

4. Pain Intensity: How does it affect your daily activities?

□Doesn't Affect □Somewhat Affects
□Seriously Affects □Prevents Activity

5. Does this pain radiate into other body parts?

Head □L □R □B
Neck □L □R □B
Shoulder □L □R □B
Arm □L □R □B
Hand □L □R □B
Hip □L □R □B
Leg □L □R □B
Foot □L □R □B
Other:_____

6. Actions affecting this pain

Brings On/Aggravates/Relieves

□In the AM □ □ □
□In the PM □ □ □
□Bend forward □ □ □
□Bend back □ □ □
□Bend left □ □ □
□Bend right □ □ □
□Twist left □ □ □
□Twist right □ □ □
□Coughing □ □ □
□Sneezing □ □ □
□Straining □ □ □
□Standing □ □ □
□Sitting □ □ □
□Lifting □ □ □
Other: _____
_____

Karminski Chiropractic
Natural Health and Wellness

Today's Date: _____

Patient Name:_____

Description of Symptoms Continued:

Third Current Symptom (Describe only ONE symptom per section)

1. Check on location below

□Headaches □L □R □B
Part of head:
□Front □Top □ Back
□Jaw □L □R □B
□Eye □L □R □B
□Neck □L □R □B
□Upper Back □L □R □B
□Mid Back □L □R □B
□Low Back □L □R □B
□Chest □L □R □B
□Abdomen □L □R □B
□Ribs □L □R □B
□Buttocks □L □R □B
□Shoulder □L □R □B
□Upper Arm □L □R □B
□Forearm □L □R □B
□Hand □L □R □B
□Hip □L □R □B
□Leg □L □R □B
□Foot □L □R □B
□Other Locations:_____
_____

2. Types of Pain:

□Dull □Sharp □Aching □Cutting
□Throbbing □Burning □Numbing □Tingling □Cramping
□Spasm □Stinging □Shooting □Pounding □Constricting
Other:_____

3. Pain Frequency

□¼ of awake time □¼ to ½ time
□½ to ¾ time □Most all the time

4. Pain Intensity: How does it affect your daily activities?

□Doesn't Affect □Somewhat Affects
□Seriously Affects □Prevents Activity

5. Does this pain radiate into other body parts?

Head □L □R □B
Neck □L □R □B
Shoulder □L □R □B
Arm □L □R □B
Hand □L □R □B
Hip □L □R □B
Leg □L □R □B
Foot □L □R □B
Other:_____

6. Actions affecting this pain

Brings On/Aggravates/Relieves

□In the A.M. □ □ □
□In the P.M. □ □ □
□Bend forward □ □ □
□Bend back □ □ □
□Bend left □ □ □
□Bend right □ □ □
□Twist left □ □ □
□Twist right □ □ □
□Coughing □ □ □
□Sneezing □ □ □
□Straining □ □ □
□Standing □ □ □
□Sitting □ □ □
□Lifting □ □ □
Other: _____
_____

Fourth Current Symptom (Describe only ONE symptom per section)

1. Check on location below

□Headaches □L □R □B
Part of head:
□Front □Top □ Back
□Jaw □L □R □B
□Eye □L □R □B
□Neck □L □R □B
□Upper Back □L □R □B
□Mid Back □L □R □B
□Low Back □L □R □B
□Chest □L □R □B
□Abdomen □L □R □B
□Ribs □L □R □B
□Buttocks □L □R □B
□Shoulder □L □R □B
□Upper Arm □L □R □B
□Forearm □L □R □B
□Hand □L □R □B
□Hip □L □R □B
□Leg □L □R □B
□Foot □L □R □B
□Other Locations:_____
_____

2. Types of Pain:

□Dull □Sharp □Aching □Cutting
□Throbbing □Burning □Numbing □Tingling □Cramping
□Spasm □Stinging □Shooting □Pounding □Constricting
Other:_____

3. Pain Frequency

□¼ of awake time □¼ to ½ time
□½ to ¾ time □Most all the time

4. Pain Intensity: How does it affect your daily activities?

□Doesn't Affect □Somewhat Affects
□Seriously Affects □Prevents Activity

5. Does this pain radiate into other body parts?

Head □L □R □B
Neck □L □R □B
Shoulder □L □R □B
Arm □L □R □B
Hand □L □R □B
Hip □L □R □B
Leg □L □R □B
Foot □L □R □B
Other:_____

6. Actions affecting this pain

Brings On/Aggravates/Relieves

□In the AM □ □ □
□In the PM □ □ □
□Bend forward □ □ □
□Bend back □ □ □
□Bend left □ □ □
□Bend right □ □ □
□Twist left □ □ □
□Twist right □ □ □
□Coughing □ □ □
□Sneezing □ □ □
□Straining □ □ □
□Standing □ □ □
□Sitting □ □ □
□Lifting □ □ □
Other: _____
_____

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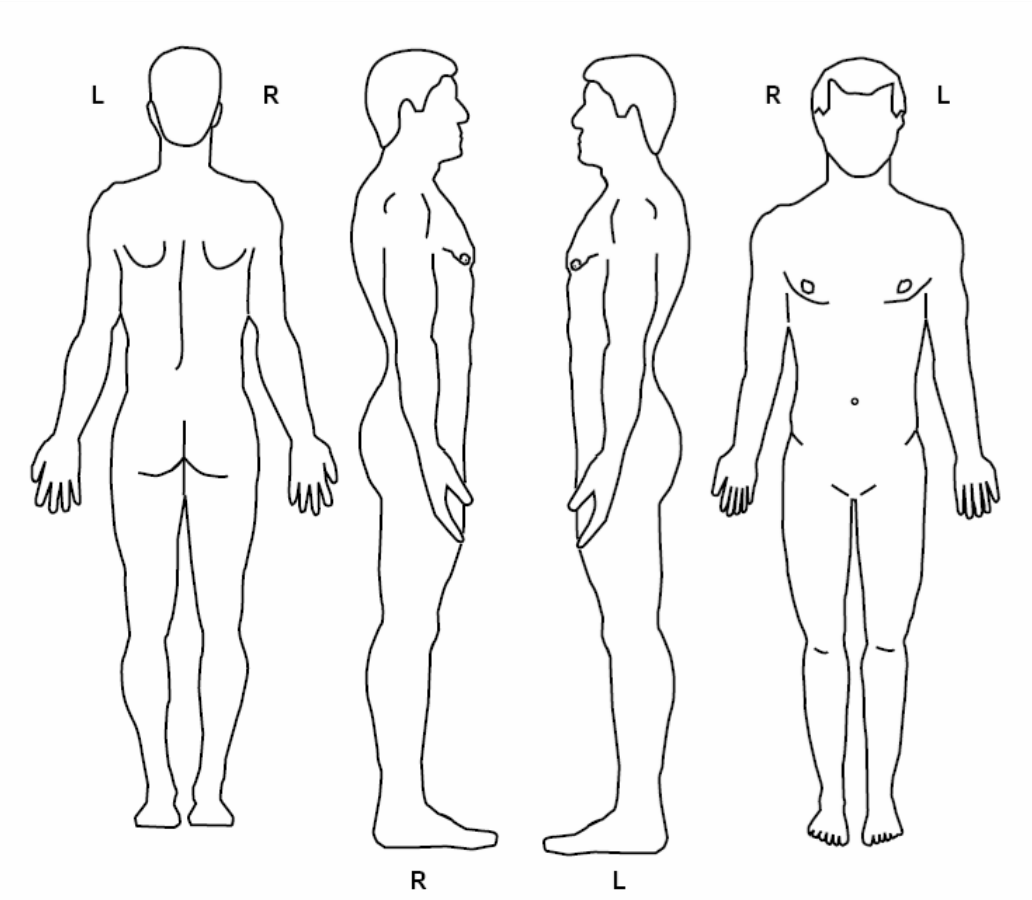
Pain Drawing

Name:_____ Date: _____
Last, First MM/DD/YYYY

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness --------- Pins & Needles ooooo Burning Pain xxxxx Stabbing Pain ///////// Aching Pain (((((((((



Visual Analogue Scale

Please mark on the line the pain level that most accurately represents your pain:

No Pain:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Unbearable Pain**
Right Now:	0	1	2	3	4	5	6	7	8	9	10	_____
Average Pain:	0	1	2	3	4	5	6	7	8	9	10	_____
At Best	0	1	2	3	4	5	6	7	8	9	10	_____
At Worst:	0	1	2	3	4	5	6	7	8	9	10	_____

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Medication Chart

Name:_____ Date: _____
Last, First MM/DD/YYYY

Help us care for you better by telling us what prescriptions and over the counter medications you take. Update this every time you visit.

Prescriptions						
Name of medicine	Dose (total milligrams)	How many times per day?	When do you take it? (Morning and night? After meals?)	Who Prescribed it for you? (physician's last name)	Why do you take it?	Do you have any side effects? Describe them.
Over-the-counter medications, herbal remedies, vitamins						

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COMPREHENSIVE MEDICAL HISTORY

Patient:_____ DOB: _____ Date: _____
Last, First MM/DD/YYYY MM/DD/YYYY

NAME OF GENERAL PRACTITIONER:
_____

DATE OF LAST PHYSICIAL EXAMINATION: _____

_____

INSTRUCTIONS FOR PAST MEDICAL-SYSTEMS REVIEW: *Please check if you now, or ever, have experienced the following:*

CONSTITUTIONAL
1. ____Cancer
2. ____Allergies
3. ____Fever or chills
4. ____Weight loss or gain
5. ____Night sweats
6. ____Fatigue
7. ____Insomnia or changes in sleep
8. ____Other

_____

ENDOCRINE
9. ____Diabetes
10. ____Thyroid disease
11. ____Intolerance to heat or cold
12. ____Increased thirst
13. ____Other

_____

EYE, EAR, NOSE, THROAT
14. ____Glaucoma
15. ____Sinusitis
16. ____Poor vision
17. ____Pain in eye
18. ____Deafness/Difficulty hearing
19. ____Nosebleeds
20. ____Dental problems
21. ____Hoarseness
22. ____Other

_____

PULMONARY
23. ____Asthma
24. ____COPD
25. ____Tuberculosis
26. ____Pneumonia
27. ____Difficulty breathing/ shortness of breath
28. ____Wheezing
29. ____Chronic cough or phlegm
30. ____Coughed up blood
31. ____Other

GASTROINTESTINAL
32. ____Appendicitis
33. ____Jaundice, Hepatitis, or Cirrhosis
34. ____Ulcer
35. ____Gallbladder disease
36. ____Colon polyps
37. ____Hemorrhoids
38. ____Poor appetite
39. ____Abdominal pain
40. ____Black or bloody stool
41. ____Frequent heartburn
42. ____Frequent bloating or gas
43. ____Frequent nausea or vomiting
44. ____Frequent diarrhea or constipation
45. ____Difficult swallowing
46. ____Other

_____

CARDIOVASCULAR
47. ____Heart disease
48. ____High cholesterol or triglycerides
49. ____High blood pressure
50. ____Stroke
51. ____Rheumatic fever
52. ____Chest pain
53. ____Irregular/rapid heartbeat
54. ____Fainting/lightheadedness
55. ____Ankle swelling
56. ____Varicose veins
57. ____Other

_____

BLOOD/LYMPH
58. ____Anemia
59. ____Bleeding disorder
60. ____Enlarged lymph nodes
61. ____Other

_____

SKIN
62. ____Change in mole
63. ____Itching or rash
64. ____Other

Doctor's Comments:

Karminski Chiropractic
Natural Health and Wellness

COMPREHENSIVE MEDICAL HISTORY

Patient:_____ DOB: _____ Date: _____
Last, First MM/DD/YYYY MM/DD/YYYY

GENITOURINARY
65. ____Kidney disease or stones
66. ____Urinary infection
67. ____Sexually-transmitted disease
68. ____Sexual difficulties
69. ____Frequent or painful urination
70. ____Bloody or discolored urine
71. ____Incontinence
72. ____Other

_____

MALE SPECIFIC
73. ____Prostate disease
74. ____Testicular pain or swelling
75. ____ Impotence/erectile dysfunction
76. ____Difficulty urinating
77. ____Other

_____

FEMALE SPECIFIC
78. Date last period began: _____
79. ____Live births
80. ____Miscarriage or abortion
81. ____Painful periods
82. ____Irregular or heavy periods
83. ____Breast lump or pain
84. ____Hot flashes
85. ____Other

_____

NEUROLOGIC/PSYCH
86. ____Epilepsy or seizures
87. ____Headache
88. ____Psychiatric disorder
89. ____Weakness
90. ____Numbness/tingling
91. ____Dizziness
92. ____Tremor or twitching
93. ____Arm/leg pain
94. ____Depression or Anxiety
95. ____Other

_____

MUSCULOSKELETAL
96. ____Fracture or dislocation
97. ____Arthritis
98. ____Scoliosis/ Spinal curvature
99. ____Neck or upper back pain
100. ____Lower back pain
101. ____Swollen/painful joint(s)
102. ____Other

CHILDHOOD DISEASES
103. ____Measles
104. ____Mumps
105. ____Chicken Pox
106. ____Other

_____

TRAUMA
107. ____Motor vehicle accident
108. ____Other

_____

HOSPITALIZATIONS and SURGERIES
(list dates and reasons)
109._____
110._____

SOCIAL HISTORY
111. ____Smoking/ tobacco use
112. ____Alcohol use
113. ____Recreational drug use
114. ____Sexually active with multiple partners
115. Are you married/partnered?
Yes No

_____

Describe your exercise:
116._____
Describe your diet:
117._____
What is your occupation?
118._____
Do you have a supportive home environment?
119._____

FAMILY HISTORY
120. ____Kidney disease
121. ____Heart disease or stroke
122. ____High blood pressure
123. ____Cancer
124. ____Thyroid disease
125. ____Diabetes
126. ____Neurological disease
127. ____Musculoskeletal disease
128. ____Psychiatric disease
129. ____Other

Doctor's Comments: