

# Kraft Chiropractic Clinic

## PATIENT INTRODUCTION FORM

(Please print)

Date \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ SS # \_\_\_\_\_ ( ) Male ( ) Female No. of Children \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Occupation \_\_\_\_\_ Email Address: \_\_\_\_\_

Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of spouse (name of parent, if minor) \_\_\_\_\_

Occupation \_\_\_\_\_ Birth date \_\_\_\_\_ SS # \_\_\_\_\_

Parent's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(if a minor)

Person responsible for account ( ) Self ( ) Spouse ( ) Parent ( ) Other \_\_\_\_\_

If other, Name \_\_\_\_\_ Phone \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred by \_\_\_ Patient ( \_\_\_\_\_ ) \_\_\_ SBC Yellow Pgs. \_\_\_ Yellow Bk. \_\_\_ Hometown Dir.  
Patient name

\_\_\_ Web Page \_\_\_ Chiro Directory \_\_\_ other ( \_\_\_\_\_ )  
please list

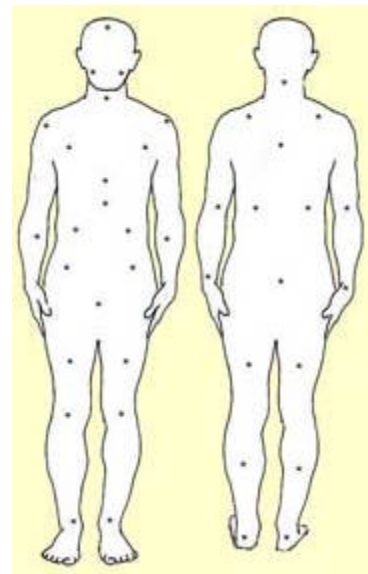
Have you had chiropractic care before? ( ) Yes ( ) No When? \_\_\_\_\_ Dr.? \_\_\_\_\_

### HEALTH HISTORY

Please check if you have had problems with any of the following (past or present):

- |                                |                     |                      |
|--------------------------------|---------------------|----------------------|
| ( ) Deafness                   | ( ) Indigestion     | ( ) Poor Health      |
| ( ) Noise in Ears              | ( ) Colon Trouble   | ( ) Trouble Sleeping |
| ( ) Choking                    | ( ) Constipation    | ( ) Nervousness      |
| ( ) Colds or Flu               | ( ) Joint Stiffness | ( ) Crying Spells    |
| ( ) Lung Trouble               | ( ) Paralysis       | ( ) Worry            |
| ( ) Sinus Trouble              | ( ) Back Trouble    | ( ) Frequent Anger   |
| ( ) Asthma                     | ( ) Arthritis       | ( ) Fear             |
| ( ) Short of Breath            | ( ) Skin Rash       | ( ) Bad Dreams       |
| ( ) High or Low Blood Pressure | ( ) Depression      | ( ) Prostate         |
| ( ) Heart Trouble              | ( ) Headaches       | ( ) Kidney Trouble   |
| ( ) Leg Cramps                 | ( ) Dizziness       | ( ) Bladder Trouble  |
| ( ) Varicose Veins             | ( ) Numbness        | ( ) Female Trouble   |
| ( ) Stomach Trouble            | ( ) Tingling        | ( ) Menstrual Cramps |
| ( ) Nausea                     | ( ) Exhaustion      | ( ) Discharge        |
|                                | ( ) Weakness        | ( ) Nerve Pains      |

### SHADE PROBLEM AREAS



Major Complaints: \_\_\_\_\_  
\_\_\_\_\_

Position of greatest pain: \_\_\_\_\_

When did you first become sick (injured)? \_\_\_\_\_

Accidents? \_\_\_\_\_ Surgery? \_\_\_\_\_

How many doctors have you consulted for your present condition? \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_

How long has it been since you were truly well? \_\_\_\_\_

How does your present condition interfere with normal living or work? \_\_\_\_\_  
\_\_\_\_\_

Do you desire:      Maximum improvement ( )      Temporary Relief ( )

### INSURANCE INFORMATION

#### CHECK TYPE OF INSURANCE COVERAGE AVAILABLE:

- |  |  |
|--|--|
| <input type="checkbox"/> Worker's Compensation       | <input type="checkbox"/> Personal Policy |
| <input type="checkbox"/> Automobile Insurance Policy | <input type="checkbox"/> Medicare        |
| <input type="checkbox"/> Group Policy                | <input type="checkbox"/> Other _____     |

Company Name \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. The benefits provided by your insurance company are **not a guarantee** of payment. Therefore, although we will file the claims with your insurance company, by signing this you agree that you are responsible for any unpaid portion of services rendered.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### OUR PERSONAL CONCERN

Our professional and personal concern is with just two things, your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help.