ADOLPH & KALKSTEIN
CHIROPRACTIC

200 E. Joppa Road ▪ Suite 300 ▪ Towson, MD 21286 ▪ 410-296-7700

PERSONAL INFORMATION

Name _____ Date _____

Home Address_____ City_____ State ____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Contact Pref. H_ W_ C_ Email _ Birth date ___/___/____ Age ____ SS # _____-_____-_____

Marital Status (circle one) Single Married Divorced Widowed

Number of Children and Ages _____

Employer _____ Occupation_____

SPOUSE'S INFORMATION

Name of Spouse_____ Employer _____

Spouse's Birth date _____ Spouse's S.S. #_____-_____-_____

OTHER INFORMATION

Emergency Contact _____ Relation _____ Phone_____

Whom may we thank for referring you? _____

Have you ever been to a chiropractor? Yes_ No_ Who?_____ When? _____

If yes, were the results satisfactory? _____

Purpose of this appointment _____

PRIMARY CARE PHYSCIAN

Physician: _____ Phone: _____
May we update them on your condition? Yes _____ No _____

INSURANCE INFORMATION– If insured, please provide your insurance card to copy.

Relationship to insured Self____ *Spouse____ *Parent____

* If other than "Self" provide Name and Date of Birth of insured:

Name: _____ D.O.B _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and the policyholder. I authorize this office to release any medical information and to complete any usual and customary reports to assist in collecting information from my insurance company. I understand that I am ultimately responsible for payment in full at this office.

Patient's Signature _____ Date _____

INJURY INFORMATION

Describe your major complaint _____

When did your problem begin? (specific date if possible) _____

How did your problem begin? _____

_____

What increases your pain? _____ **decreases?** _____

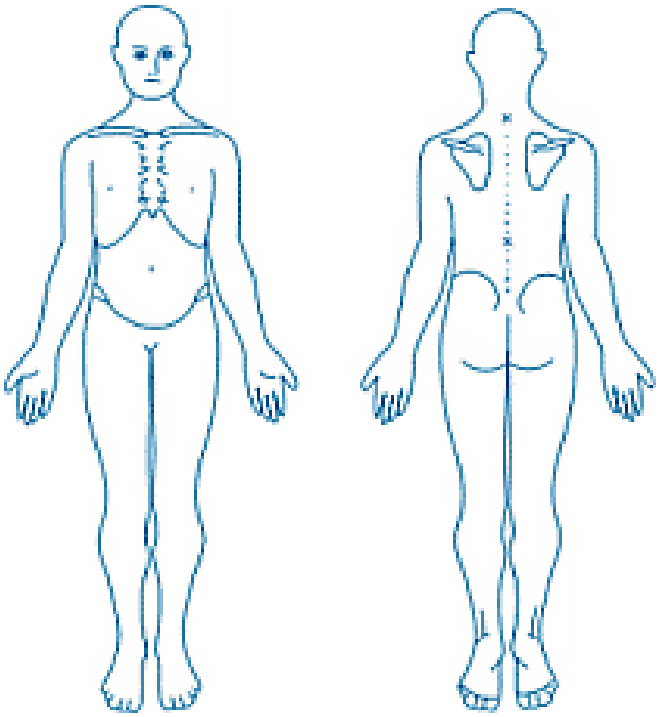
How many days a week do you experience pain/discomfort? _____ **days**

Are your symptoms ___Decreasing ___Not Changing ___Increasing

Symptoms are worse in the ___Morning ___Afternoon ___Evening ___Same all day

Has your daily activity changed as a result of your condition? If so, please explain.

No__ Yes_____



Please check the corresponding pain description and frequency for each area (1,2,3, etc) indicated on the diagram to the left.

Description	Area 1	2	3	4
Sharp pain				
Dull pain				
Ache				
Weak				
Throbbing				
Numb				
Shooting				
Gripping				
Burning				
Tingling				
Frequency				
Constant (76-100%)				
Frequent (51-75%)				
Intermittent (26-50%)				
Occasional (25% or less)				
Other				

Indicate your pain by circling your highest pain level and lowest pain level for each area indicated above.

Area: 1 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

2 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

3 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

4 No Pain 1-------2-------3-------4-------5--------6-------7-------8-------9-------10 Unbearable

What treatments have you previously tried for this condition?
Physical Therapy ___ Chiropractic ___ Massage ___ Orthopedic ___
Family/Primary Doctor ___ Other _____
If so, please write name _____

Have you had Spinal X-Rays, MRI, CT SCAN? __No __Yes:
Date(s) taken: _____ Area taken _____
_____ _____

Below please list all doctors you have seen since your accident/ onset of pain:
Name of doctors_____
_____

Condition(s) being treated:
_____

List all prescription, non prescription medications and other supplements you take as well associated condition:
_____
_____
_____

List any surgeries or hospitalizations you have had including month and year:
_____
_____
_____

List any allergies: _____
Family History:_____
_____

Do you exercise: ____Yes ____No Hours per week?____
What activities:_____
Are you dieting? ____Yes ____No Since?___
Do you smoke? ____Yes ____No Packs per day?____ How many years? ____
Do you drink alcoholic beverages? ____Yes ____No Drinks per day _____
For Women: Are you pregnant/nursing? ____Yes ____No How many weeks: _____
Last menstrual cycle: _____

Please circle all that apply below:

AIDS/HIV	**Breast Lump**	**Emphysema**	**Measles**	**Stroke**
Bleeding	**Diabetes**	**Heart Disease**	**Parkinson's**	**V.D**
Depression	**Gout**	**Liver Disease**	**Rheumatoid**	**Arthritis**
Gonorrhea	**Kidney Disease**	**Osteoporosis**	**Miscarriage**	**Cataracts**
High Cholesterol	**Mumps**	**Implants**	**Appendicitis**	**Goiter**
Pacemaker	**Prosthesis**	**Typhoid**	**Herniated Disc**	**Cancer**
Prostate	**Tumors**	**Anorexia**	**Fractures**	**Ulcers**
Tuberculosis	**Blood Pressure**	**Bulimia**	**Hernia**	**M.S.**
Chronic fatigue	**Anemia**	**Epilepsy**	**Migraines**	**Thyroid**
Allergy Shots	**Bronchitis**	**Hepatitis**	**Polio**	**Asthma**
Chicken Pox	**Whooping cough**	**Glaucoma**	**Herpes**	**Mono**
Pneumonia	**Tonsillitis**	**Fibromyalgia**	**Other: _____**	

* All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature: _____ Date: _____