Dr. Kristie Chiropractic, LLC
310 Huey P Long Ave Suite 100
Gretna, LA 70053
(504) 636-6036

Please Print and Answer All Questions

Date _____

Last Name _____ First _____ Middle _____

Address _____ Apt. ___ City _____ State _____ Zip _____

Cell Phone # _____ Alternate Phone # _____

Email Address _____

Gender _____ Date of Birth _____ Age_____ Marital Status (circle one) S M D W

Occupation_____

Emergency contact: Name _____ Phone # _____ Relation _____

How did you hear about our office _____

Is there any chance that you could be pregnant? ____Y ____N Are you nursing? ____Y ____N

Height_____ Weight_____

Have you been treated by a chiropractor before? ____Y____N

Patient Condition

Circle <u>ONE</u> of the following areas of complaint:

Neck Mid back Lower back

Other:_____

Is this pain due to an accident? ____Y ____N If yes, date and details _____

Major Surgeries/Illnesses and Dates: _____

Do you take any vitamins or supplements? ____Y ____N If yes, please list brand, type and dosage: _____

Do you wear foot othotics? ____Y ____N If yes, please list brand, type and duration: _____

Symptoms

When did you first notice the pain? _____

Circle the following answers:

Is the pain getting progressively worse? Yes No is the pain: Constant Intermittent

Describe the pain: Sharp Dull Throbbing Shooting Aching Stiff Burning
Tingling Cramping Swelling Numbness Other _____

On a scale of 1 (least pain) to 10 (severe pain), rate the pain: 1 2 3 4 5 6 7 8 9 10

Does the pain interfere with: Work Sleep Physical Activity Daily Routine?

Does the pain increase when you: Sit Stand Bend Lie down Walk Run Lift Weights

Have you missed work because of the pain: Yes No

How many days? _____?

Health Insurance Information

Insurance Company _____

Policy/Member ID# _____ Group #_____

Name of Insured (if different from patient) _____ Relation _____

DOB of insured (if different from patient) _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of the visit.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date _____