General Information

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

Phone: _____ ☐ **Cell /** ☐ **Home**

Occupation: _____

Employer: _____

How did you hear about us?_____

_____

Is this your first treatment from a chiropractor?

☐ **YES /** ☐ **NO**

Emergency Contact Information:

Name: _____

Relationship: _____

Phone: _____ ☐ **Cell /** ☐ **Home**

Notes: _____

_____

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Reason for Visit

What is the reason for your treatment today?

_____

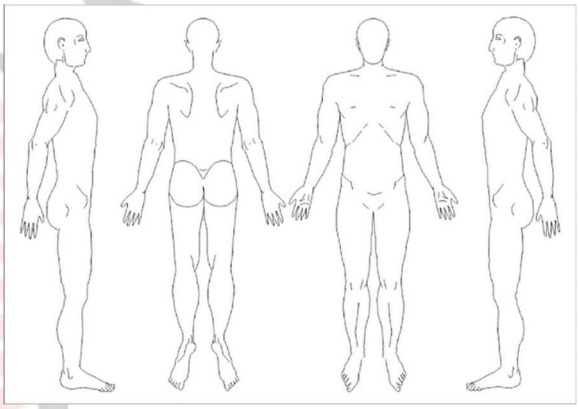
_____

Have you received treatment for this condition in the past?

☐ **YES /** ☐ **NO**

Using the symbols below, please mark any areas where you are experiencing:

(X) Pain **(O)** Numbness/Tingling **(#)** Burning



How severe is you discomfort on a scale of 0-10?

On average_____ At worst? _____ At Best? _____

Check the boxes which describe your symptoms:

☐ Constant ☐ Comes and goes ☐ Aching

☐ Worse in the morning ☐ Dull ☐ Sharp

☐ Worse at night ☐ Shooting ☐ Throbbing

When did your symptoms first appear?_____

_____

What if anything makes your symptoms_____ better?_____

What if anything makes your symptoms_____ worse?_____

Health History

Recent signs and symptoms: (Check all that apply)

- ☐ Constant Pain
- ☐ Unexpected weight loss or gain
- ☐ Urinary or fecal incontinence
- ☐ Abdominal Bleeding
- ☐ Fatigue
- ☐ Excessive Thirst
- ☐ Frequent / Painful Urination
- ☐ Excessive Brusing
- ☐ Fever, Chills, Sweats
- ☐ Nausea / Vomiting
- ☐ Blood in Urine
- ☐ Difficulty Breathing
- ☐ Changes in Appetite
- ☐ Severe Abdominal Pain
- ☐ Black / Bloody Stools
- ☐ Tightness in Chest

Have you ever had any of the following symptoms:

- ☐ Cancer ☐ Hypertension
- ☐ Recurring Sinusitis ☐ Heart Attack
- ☐ Disc Herniation or Bulge
- ☐ Anemia ☐ Pacemaker
- ☐ Bloating ☐ Arthritis
- ☐ Bleeding disorder ☐ Stroke
- ☐ Belching or gas ☐ Osteoporosis
- ☐ Swelling in ankles or legs ☐ Kidney Disease
- ☐ Rheumatoid Arthritis ☐ Allergies
- ☐ Cardiovascular Disease ☐ Depression
- ☐ Recurring Ear Infections ☐ Glaucoma
- ☐ Latex Allergy ☐ Anxiety
- ☐ Sprained Ankle ☐ Clotting Disorder
- ☐ Drug or Alcohol Dependency
- ☐ Bruise Easily ☐ Psoriasis

Are you currently or trying to get pregnant?

☐ NO ☐ YES, Expected date: _____

Please list any hospitalizations or surgeries with approximate dates: _____

Please list any vitamins and or supplements:

Please list any medications:

Please list and allergies:_____

Lifestyle

Exercise:

- [ ] None
- [ ] Minimal (1-2X per week)
- [ ] Moderate (more than 3-4X per week)
- [ ] Daily (7X per week)
- [ ] Excessive (multiple times per day)

Work Activity:

- [ ] Sitting
- [ ] Standing
- [ ] Light labor
- [ ] Moderate Labor
- [ ] Heavy Labor

Habits:

- [ ] Smoking frequency: _____
- [ ] Alcohol frequency: _____
- [ ] Recreational Drugs / Type: _____
- [ ] Caffeine frequency: _____
- [ ] High Stress / Reason: _____

Sleep:

Average number of hours per night? _____

_____

I normally sleep on my:

- [ ] Back
- [ ] Stomach
- [ ] Side
- [ ] Toss and turn

Nutrition:

How would you describe your eating habits?

_____

_____

- [ ] I eat whatever and whenever I want.
- [ ] I make attempts to eat right, but struggle.
- [ ] Most of the time I choose to eat right, but on occasion I treat myself.
- [ ] I strictly regulate my food intake, all the time.
- [ ] I am all over the board. No Consistency.

Authorization to Provide Care

I authorize the physicians at Kraken Sport and Spine to administer treatment included but not limited to: manual manipulation, soft tissue techniques, passive therapies and or any treatment, within the scope of chiropractic practice, they deem appropriate for regaining and/or maintaining neuromusculoskeletal health, unless I expressly refuse beforehand.

Print name: _____

Signature: _____

Date: _____

Consent to Treat a Minor, if applicable

I, (Print Name) _____, authorize the physicians at Kraken Sport and Spine to examine and treat my _____.

Minor's Printed name: _____

Legal Guardian Signature:

_____

Date: _____

Payment Policy

I understand the payment for services rendered, per fee schedule listed at: https://www.krakensportandspine.com, will be due on the date of service and accepted in the form of cash, check, charge, and digital payment such as; Apple pay, Google pay, venmo or cashapp. I may choose to submit a reimbursement claim directly to my insurance provider. Kraken Sport and Spine will supply any additional documentation regarding my treatment needed for this purpose, at my request.

Print name: _____

Signature: _____

Receipt of Notice of Privacy Practices

I have been offered a copy of the Kraken Sport and Spine's Notice of Privacy Practices, which provides an explanation of my rights with respect to my personal health information and the privacy practices of this clinic, in accordance with the Health Insurance Portability & Accountability Act (HIPPA) of 1996. I understand I can review this Notice anytime at: https://www.krakensportandspine.com

Print name: _____

Signature: _____