



KIRAR CHIROPRACTIC WELLNESS

Plantation Point Shopping Center
5 South Alliance Drive Suite E
Goose Creek, S.C. 29445

CHIROPRACTORS WITH THE HEALING TOUCH

Phone: 572-2224
Fax: 572-2274

CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Date: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Phone: Home _____ Work _____ Ext. _____

Birth date: ____/____/____ Age: _____ Sex: F M SS#: _____

Single Married Divorced Widowed Separated How many children: _____

Occupation: _____ Employer: _____

Name of Emergency Contact: _____ Phone: _____

How were you referred? Location Yellow pages Health presentation other _____

Who may we thank for referring you? _____

Reason for Visit: _____ Began? _____

Have you seen other doctor's for your present condition? _____ If Yes, Whom? _____

Medication you are currently taking: _____

Major Surgery/Operations: _____

Major Accident or Falls: _____

Financial Information

Who is responsible for account? _____

Relationship to patient: _____

Are you insured? Yes No Insurance Company: _____

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand and authorize the release of any information necessary for Kirar Chiropractic Wellness to secure the payment of benefits and that any amount authorized to be paid directly to Kirar Chiropractic Wellness will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he/she deems appropriate through the use of chiropractic adjustments and adjunctive therapies. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the Radiographs will remain the property of Kirar Chiropractic Wellness, being on file where they may be seen at any time. The Doctor will not be held responsible for pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient or Responsible Party Signature

Date

Guardian or Spouse's Signature Authorizing Care

Date

PAST HISTORY: Please check all of the conditions, which you have or had in the last 6 months. We need your complete health report before we can be responsible for your case. If none of the conditions exist, disregard.

General

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Depression
- Numbness
- Sweats
- Tremors

Musculo-skeletal

- Arthritis
- Bursitis
- Low back pain
- Neck pain
- Pain b/w shoulders

Respiratory

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Wheezing

Gastro-intestinal

- Bleaching
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Bloating abdomen
- Excessive hunger
- Difficult digestion
- Gallbladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Vomiting
- Vomiting of blood

Cardio-vascular

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heartbeat
- Swelling of ankles

EENT

- Asthma
- Crossed eyes/
Nystagmus
- Deafness
- Dental decay
- Earache
- Ear discharge
- Ear noise/Ringing
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Visual disturbances
- Far sightedness
- Hay fever
- Near sightedness
- Nose bleeds
- Sinus infection
- Sore throat
- Tonsillitis

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

Genito-urinary

- Bed-wetting
- Blood in urine
- Frequent urination
- Lack of kidney control
- Kidney infection
- Painful urination
- Prostate trouble
- Pus in urine

Women only

- Congested breast
- Cramps or backache
- Excess menstrual flow
- Hot flashes
- Irregular cycles
- Lumps in breast
- Menopause
- Painful menstruation
- Vaginal discharge

**When was the first day of your last period? _____

Is there any possibility that you are pregnant? Yes No

Due Date: _____

Check any of the following conditions you have or have had:

- | | | | |
|---|-------------------------------------|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Chorea | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Stoke / TIA |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> MS | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Pleurisy | |

Habits: None How much?

- | | |
|--|--|
| Alcohol <input type="checkbox"/> _____ | Exercise <input type="checkbox"/> _____ |
| Coffee <input type="checkbox"/> _____ | Sleep <input type="checkbox"/> _____ |
| Tobacco <input type="checkbox"/> _____ | Appetite <input type="checkbox"/> _____ |
| Drugs <input type="checkbox"/> _____ | Soft drinks <input type="checkbox"/> _____ |

When did you last have.....

- Spinal X-rays _____
- Spinal exam _____
- Physical exam _____

Family Health History: If history exists list relationship of person. (mother, father, brother, sister, spouse, etc.)

- | | | |
|-----------------|----------------------|------------------------|
| Arthritis _____ | Cancer _____ | Seizures _____ |
| Scoliosis _____ | Thyroid _____ | Headaches _____ |
| Back/disc _____ | Diabetes _____ | Strokes _____ |
| Asthma _____ | Mental illness _____ | Kidney disease _____ |
| | | High Blood Pres. _____ |

