



We look forward to meeting you at Compass Chiropractic!

Dr. Krohse at Compass Chiropractic has a reputation for performing the most thorough exam to determine all the causes of your pain or condition. In order to make your first visit as efficient and effective as possible please take a look at the following checklist:

Before your visit:

- Previous Imaging: Contact Compass Chiropractic if you have had X-Rays, MRI's, or other imaging of the problem area performed within the last two years to find out if you should pick them up ahead of time.
- Automobile and Work Injuries: Contact Compass Chiropractic if you consider your injury to be caused by a car accident or work injury to find out what extra paperwork you may be able to fill out before your visit.
- Paperwork: Fill out the attached paperwork. If you forget your paperwork the day of your visit, please plan to arrive 10 minutes earlier than your scheduled visit to allow time to fill out paperwork.

Bring the day of your visit:

- Filled out paperwork
- Previous imaging if applicable
- Any applicable insurance card/cards
- Cash, check, or credit/debit card to cover your financial responsibility
- * Toys and books are available to keep your little ones occupied during your first visit if needed

Directions:

From 235	From University Avenue	Heading south on 73rd Street from Hickman
<ol style="list-style-type: none">1. Exit 73rd/8th Street2. Head north3. As you approach University Avenue get in the left turn lane that is further to the right4. Turn left onto University and turn into the first parking lot after the Flowerama	<ol style="list-style-type: none">1. See Compass Chiropractic on the north side of University Avenue just west of the Flowerama on the northwest corner of 73rd and University Ave	<ol style="list-style-type: none">1. Turn right at University Avenue2. Take the first right driveway after the Flowerama



Dr. David Krohse
P: 515.309.1217

7405 University Ave, #1
Clive, IA 50325

Chiropractic Case History/Patient Information

Date: _____

Patient # _____

PERSONAL INFORMATION

Name: First _____ Preferred _____ MI _____ Last _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: _____ Home Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D

Occupation: _____ Employer: _____

Office Phone: _____ Spouse: _____

Names and Ages of Children: _____

Emergency Contact: _____ Phone: _____

Who can we thank for referring you to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

PAST MEDICAL HISTORY

Do you have a history of stroke or hypertension? _____

Have you had any significant illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

SYMPTOM REVIEW

Check symptoms/conditions you are experiencing or feel may be relevant

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Loss of Sleep |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Gastro-intestinal issues |
| <input type="checkbox"/> Lower Back | <input type="checkbox"/> Skin issues |
| <input type="checkbox"/> Hips | <input type="checkbox"/> Unexplained swelling |
| <input type="checkbox"/> Legs | <input type="checkbox"/> Racing heart |
| <input type="checkbox"/> Knees | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Difficulty or abnormal urinating |
| <input type="checkbox"/> Sciatica (down back of leg) | <input type="checkbox"/> Women: Menstrual abnormalities |



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Date: _____ Patient Name: _____ Patient # _____

SOCIAL HISTORY

Estimated alcoholic beverages per week? _____
Do you use any tobacco products? _____ Do you smoke? _____
Do you take vitamin supplements? _____ If so, please list: _____
Sleeping Position (s): Back Side fetal position side/front sprawled out front head turned front face down
Frequency and types of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting _____ sitting _____ bending _____ working at a computer _____

FAMILY HISTORY

Do you have any family members who suffer from the same condition you do? If so, please list: _____
FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **C**hild/Children, **H**usband, **W**ife):
Back Problems _____ Neck Problems _____ Headaches _____ Arthritis _____ Cancer _____
Other _____

PRIOR EXPERIENCE & NUTRITIONAL CONSULTATION OPT IN/OUT

Previous Chiropractic Experience: Positive _____ Negative _____ None _____
Comments: _____
Are you interested in discussing nutritional improvement/supplementation options to support your body's healing potential? Yes _____ No _____

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case:
 Major Medical Worker's Compensation Medicaid Medicare Auto Accident
 Medical Savings Account & Flex Plans Other _____

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

E-NEWSLETTER CONSENT


May we have permission to periodically email you Compass Chiropractic newsletters (An option to stop receiving newsletters will be on every email) Yes No

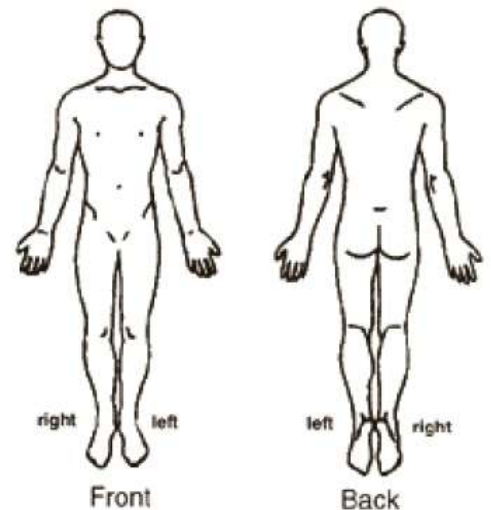
SUMMARY

Date: _____ Patient Name: _____ Patient # _____

1. What are your major symptoms? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No _____. If yes, describe: _____
Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____
6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Walking ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
11. Please circle your overall pain level below. On the right, label the areas of discomfort with a letter descriptor, and a number pain rating for each area like the sample.

Overall Pain Scale										
Please circle the number that best describes your pain										
0	1	2	3	4	5	6	7	8	9	10
NONE		LITTLE			MEDIUM				SEVERE	

Pain Diagram Key		Sample:
A = Aching	N = Numb	
B = Burning	T = Tingle	
S = Stabbing		



Additional info: _____