Compass Chiropractic

Dr. David Krohse
P: 515.309.1217

7405 University Ave, #1
Clive, IA 50325

Chiropractic Case History/Patient Information

Date:_____

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 Spouse:_____

Occupation:_____ Employer:_____

Office Phone:_____Spouse' Employer:_____

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 symptomatic regions or conditions you are experiencing or have had issues with

Neck Nerve Control
- ❑ Neck
- ❑ Headaches
- ❑ Shoulders
- ❑ Elbows
- ❑ Hands
- ❑ Blood Pressure/Heart
- ❑ Thyroid/Low Energy
- ❑ Anxiety/Sleep Issues
- ❑ Dizziness/Vertigo
- ❑ Depression
- ❑ Allergies/congestion

Upper Back Nerve Control
- ❑ Upper back
- ❑ Rib region
- ❑ Breathing/asthma issues
- ❑ Digestion/acid reflux issues
- ❑ Diabetes/blood sugar control

Low Back Nerve Control
- ❑ Low back pain
- ❑ Hip pain
- ❑ Sciatica (back of leg)
- ❑ Knee pain
- ❑ Lower leg
- ❑ Feet/ankles
- ❑ Constipation
- ❑ Difficulty or abnormal urinating
- ❑ Sexual/reproductive issues
- ❑ Menstrual abnormalities

General
- ❑ Unexplained weight loss/gain
- ❑ Fever
- ❑ Skin changes
- ❑ Changes in thirst

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Date:_____ Patient Name: _____

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?_____

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**:**

❑ Group/Individual Health Insurance ❑ Worker's Compensation ❑ Medicaid ❑ Medicare ❑ Auto Accident

❑ 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

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SUMMARY

Date:_____ **Patient Name:** _____

What is your main problem?_____

_____

_____

_____

Describe any other problems you're experiencing: _____

_____

_____

_____

_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ❑ Yes ❑ No ❑ Uncertain

Below, circle the areas you'd like us to focus on: