Dr. David Krohse
P: 515.309.1217

7405 University Ave, #1
Clive, IA 50325

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
1. Exit 73rd/8th Street 2. Head north 3. As you approach University Avenue get in the left turn lane that is further to the right 4. Turn left onto University and turn into the first parking lot after the Flowerama	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	1. Turn right at University Avenue 2. Take the first right driveway after the Flowerama

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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 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:** ______________________ **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**:**
☐ 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:** ______________________ **Patient #**___________

1. **What is your main problem?** ____
   ____
2. How and when did it start?____
   ____
3. How frequent is it? Constant _____ Daily ____ Intermittent ____ Night Only _____
4. Describe the sensation: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other ____
5. Does anything make it better? ____
6. What makes the problem worse? ____
7. Share the range of your pain or frustration (0=none, 10=worst imaginable):________________________
8. Additional info: ____
   ____

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: