Kutschman Chiropractic & Acupuncture Center
Confidential Patient Information

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case. THANK YOU.

Name__________________________________ DOB _____________ SSN___________________

Address____________________________ City ______________ St. ___________ Zip _________

Home # ________________________ Work # ___________________ Cell # __________________

Email____

Emergency Contact________________________________ Phone # ________________________

Name and Address of Employer ____

Occupation _____________________________ Marital Status S M W D

Whom may we thank for referring you? ____________________________________

Health Information

Have you had previous chiropractic care? □ Yes □ No
Main Complaint _________________________________

Other Complaints _______________________________
How long? _____________________________________
Similar conditions in the past? ____________________
Does this affect your work? □ Yes □ No
Does this affect your family/social life? □ Yes □ No
What aggravates this condition? _________________
Other Dr.'s for this condition? ___________________
What helps your symptoms? ____________________
Are you taking any medications? □ Yes □ No
If yes, what kind? ______________________________
Any surgeries, falls or accidents? □ Yes □ No
Please date and explain ________________________
Date of last physical exam _______________________

Insurance Information

Is this related to worker's compensation? □ Yes □ No
Is this related to an automobile accident? □ Yes □ No
Do you have major medical insurance? □ Yes □ No

Are you covered by Medicare/Medicaid? □ Yes □ No

Do you suffer from:

	YES	NO
Headaches	□	□
Neck Pain	□	□
Arm Pain	□	□
Shoulder Pain	□	□
Back Pain	□	□
Hip/Leg Pain	□	□
Chest Pain	□	□
Abdominal Pain	□	□
Sinus Trouble	□	□
Heart Trouble	□	□
Palpitation	□	□
Circulatory	□	□
High Blood Pressure	□	□
Low Blood Pressure	□	□
Prostate Disorder	□	□
Kidney Problems	□	□
Bladder Problem	□	□
Lung Disorder	□	□
Bronchial Disorder	□	□
Digestive Disorder	□	□
Constipation	□	□
Loose Stool	□	□

Patient Signature ____________________________________ Date ___________________