Email Address:_____Cell Phone: _____

PATIENT INFORMATION

Please print and answer the following questions as accurate and complete as possible.

Today's Date: _____

PERSONAL INFORMATION

Legal Name: _____ **Age:** _____ **Sex:** ☐M ☐F
(First) (MI) (Last)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Date of Birth:** _____/____/_____ **SS#** _____-____-_____

Business/Employer: _____ **Work Phone:** _____

Type of Work Performed: _____ **Marital Status:** ☐M ☐S ☐W ☐D

Spouse's Name: _____ **Children? Sons:** _____ **Dau:** ____

Emergency Contact: _____ **Phone:** _____

Who is Your Family Physician? _____ **City:** _____ **State:** _____

How did you hear about this office? _____

CURRENT HEALTH CONCERNS

Reason For Today's Visit(be specific): _____

When Did This Begin: _____ **Experienced Previously?….. …. ☐Yes ☐No**

Is Condition: ☐Job Related ☐Auto Related ☐Injury ☐Other: _____

Other Doctors Seen For This Problem: _____

Previous Doctor's Opinion/Diagnosis : _____

Were any X-rays/ MRIs done: ☐Yes ☐No **Where Done:** _____

Other or Secondary Complaints: _____

Past Health History

Major Surgeries/Operations: ☐Head ☐Neck/Throat ☐Chest/Heart/Lung
☐Back ☐Abdominal ☐Other: _____

Previous Fractures or Broken Bones: ……. ☐Yes ☐No What: _____
Previous Falls or Accidents:…….. ☐Yes ☐No When: _____
Previous Hospitalization:…….. ☐Yes ☐No Why: _____
Previous Chiropractic Care:…….. ☐Yes ☐No Doctor: _____

Medications Now Taking:…. ☐Pain Killers/Muscle Relaxants ☐Nerve/ Anti-depressants
☐Blood Pressure Medicine ☐Antibiotics ☐Insulin
☐Stomach Medicine ☐Heart ☐Vitamins/Supplements
☐Other: _____

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as thoroughly as possible.

CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

- ❑Allergies
- ❑Diabetes
- ❑Cancer
- ❑Heart Problems
- ❑Stroke
- ❑Kidney problems
- ❑Osteo-Arthritis
- ❑ Epilepsy
- ❑AIDS or ARC
- ❑ Frequent Illnesses
- ❑ Fibromyalgia
- ❑ Addictions past/present
- ❑ Rheumatoid Arthritis
- ❑ Gout
- ❑ Chronic Fatigue
- ❑ Lupus
- ❑ ALS/MS
- ❑ Parkinson's

Intake or Use :
- ❑ Alcohol
- ❑ Tobacco
- ❑ Caffeine
- ❑ Drugs of abuse

DO YOU EXERCISE REGULARLY? ❑ Yes ❑ No **ARE YOU DIETING?** ❑ Yes ❑ No **Since** _____

CHECK ANY PROBLEM AREAS THAT YOU HAVE HAD IN THE PAST YEAR:

MUSCLES-SKELETON
- ❑ Low Back
- ❑ Middle Back
- ❑ Neck
- ❑ Arm (s)
- ❑ Leg(s)
- ❑ Shoulder(s)
- ❑ Knee(s)
- ❑ Jaw -TMJ
- ❑ General Stiffness

NERVE SYSTEM
- ❑ Headaches
- ❑ Nervousness
- ❑ Depression
- ❑ Numbness/Tingling
- ❑ Muscular Weakness
- ❑ Dizziness
- ❑ Fainting
- ❑ Convulsions/Seizures
- ❑ Stress
- ❑ Shaking/Tremors

CIRCULATION-BREATHING
- ❑ Chest
- ❑ Breathing
- ❑ Blood Pressure
- ❑ Heart
- ❑ Lungs
- ❑ Poor Circulation

DIGESTION-ELIMINATION
- ❑ Poor Appetite
- ❑ Excessive Thirst
- ❑ Nausea
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Weight Loss/Gain
- ❑ Gas/Bloating
- ❑ Heartburn

MALES ONLY
- ❑ Prostate Problems
- ❑ Testicular problems
- ❑ Erectile dysfunction

EYE-EAR-NOSE-THROAT
- ❑ Eyes
- ❑ Dental
- ❑ Throat
- ❑ Ear(s)
- ❑ Nose
- ❑ Sinus

URINARY-GENITALS
- ❑ Pain Upon Urination
- ❑ Infrequent Urination
- ❑ Frequent Urination
- ❑ Weak Urine Stream
- ❑ Bladder Control

FEMALE ONLY
- ❑ Menstrual Problems
- ❑ Low Back Pain w/Periods
- ❑ Breast Lumps/Problems

Are you Pregnant?
❑ Yes ❑ No ❑ Not Sure

FAMILY HISTORY: (i.e., heart, cancer, stroke, diabetes, blood pressure, etc.)

Mother's Side: _____

Father's Side: _____

ANY OTHER PROBLEMS NOT LISTED ABOVE: _____

Signature of fact, acknowledgement of Payment Policies, and Receipt of Notice of Privacy Practices.

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge.

I understand and agree that any health or accident insurance policies that I have are an arrangement between the insurance carrier and myself and that Dr. Gale Keppel is not a party to that contract. I acknowledge that I am personally responsible for the payment of all services and products provided by Dr. Gale Keppel. I understand that payment is due at the time services are rendered and products are received, that Dr. Gale Keppel accepts only cash or check payments and does not participate in any third-party payment program. I understand that if it becomes necessary to collect any sum through an attorney and/or court of unpaid fees, then I am responsible to pay all reasonable costs of collection, including attorney's fees and court cost.

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices and Fee and Office Policy, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by the Practice.

Patient's/Parent's/Legal Guardian's Signature **Date**