MARTIN CHIROPRACTIC
KINETIC SPORTS MEDICINE

Patient Contact Information:

NAME

_____

Email Address
_____**DRIVERS LICENSE #**_____

Street Address
_____

City_____**State**_____**Zip**_____

Home Phone_____**Best Time Call**_____

Work Phone_____ **Best Time Call**_____

Date of Birth_____**Age**_____**Weight**_____**Height**_____**Gender**_____

Primary Physician (name, address and phone number)_____

_____

How did you hear about us?

_____

PRIMARY INSURANCE CARRIER

COMPANY_____ NAME OF INSURED_____

BILLING ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____ MEMBER# _____

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SECONDARY INSURANCE

COMPANY_____ INSURED_____

BILLING ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____ MEMBER#_____

PATIENT EMPLOYMENT INFORMATION

EMPLOYER_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE_____ OCCUPATION_____LENGTH_____

SPOUSE/EMERGENCY CONTACT

NAME_____ DATE OF BIRTH_____

OCCUPATION_____

Patient Family Medical History:

Please check off if anyone in your family has had problems with:

__Diabetes, Thyroid or other **__Endocrine Disorders**

__Hypertension **__Lipid Disorder**

__Cardiovascular Disease **__Prostate Disease**

__ Cancer **__Other Illness not noted**

Patient Medical History:

Please check off if you have a history or early finding of the following:

__Pregnant/Lactating **__Blood Disorders**

__Cancer **__Immune Disorders**

__Poor wound healing **__Edema/excess fluid retention**

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__High Cholesterol

__Lung Disorder

__Renal Disease

__Emotional Disorders

__Glaucoma

__Surgery

__Chemical Dependency

__Upper respiratory problems

__High Blood Pressure

__Heart Attack

__Genital-Urinary Disorder

__Carpal Tunnel Syndrome

__Drug Allergies

__Food Allergies

__Neurological disorders, Thyroid, Diabetes or other endocrine disorder including insulin resistance, or diabetes

__Any known deficiency including minerals and electrolytes

__Orthopedic or muscle disorder including fracture or joint disorders

__Heart disease including Atherosclerosis, Angina, or Heart Failure

Any other illness not noted_____

If you checked off any item above, please explain;_____

_____

_____

_____

Are you pregnant? Yes/No Last day of menstrual cycle?

_____

Do you get regular exercise?_____If yes, what type, frequency, duration, & where?_____

_____

_____

Medications used in the past 12 months?_____If yes, please list_____

Previous weight loss?_____If yes, explain if recent or long term history_____

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_____

When was the last time you were sick?_____

<u>Questions for determining factors for treatment of your medical condition:</u>

Please check off if you have had any of the following:

__Loss of concentration, sociability, activity **__Increasing mood swings**

__Increasingly stressed

__Decreasing memory / Short term___ Long term___

__Decreased desire and ability to exercise **__Difficulty sleeping**

__Decreased sense of well-being **__Increase in lack of drive**

__Depression **__Less interest in sex**

__Decreasing size of testicles **__Vaginal dryness**

__Urogenital atrophy **__Hot flashes**

__Cold or heat intolerance **__Thinning of loss of hair**

__Increasing wrinkles **__Sagging, loose or thin skin**

__Increase sagging muscles or breasts **__Decreased energy or endurance**

__Muscle loss **__Decreased muscle strength**

__Progressive osteoporosis, decreasing bone mass or stooped posture

__Increasing fat deposits about the abdomen or thighs **__Restless leg syndrome**

How many caffeinated drinks (daily)?_____

How many energy drinks (daily)?_____

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CONFIDENTIAL HEALTH QUESTIONAIRE

NAME _____ AGE_____ DATE_____

CHECK CONDITIONS THAT APPLY

GENERAL

_____ALLERGY
_____FATIGUE
_____CONSTIPATION
_____DIARRHEA
_____NAUSEA
_____VOMITTING
_____DIZZINESS
_____PAINFUL BREATHING
_____ASTHMA
_____HIGH/LOW BLOOD PRESSURE
_____FREQUENT URINATION
_____PAINFUL URINATION
_____PROSTATE TROUBLE

MUSCLE/JOINTS

_____HEADACHES
_____NECK PAIN/STIIFNESS
_____SHOULDER PAIN
_____ARM PAIN, NUMB
_____ELBOW PAIN
_____WRIST/HAND PAIN
_____MID BACK PAIN
_____LOW BACK PAIN
_____HIP PAIN
_____SCIATICA
_____KNEE PAIN
_____LEG PAIN/NUMBNESS
_____ANKLE/FOOT PAIN, NUMBNESS
_____ARTHRITIS- TYPE_____
_____OTHER

WOMEN ONLY

_____CRAMPS/ BACKACHE
_____EXCESS MENSTRUAL FLOW
_____HOT FLASHES
_____IRREGULAR CYCLE
_____LUMPS IN BREAST
_____PARI/PRE-MENOPAUSE
_____MENOPAUSE
_____MISCARRIAGE
_____PAINFUL MENSTRATION

CONDITIONS THAT YOU HAVE OR HAVE HAD

_____ALCOHOLISM	_____ANEMIA	_____ARTHROSCLEROSIS
_____CANCER	_____EMPHYSEMA	_____EPISEPSY
_____GOUT	_____HEART DISEASE	_____PACEMAKER
_____PNEUMONIA	_____STROKE	_____MULTIPLE SCLEROSIS

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REASON FOR VISIT_____

_____

HOW LONG HAVE YOU HAD THIS CONDITION?_____

GETTING WORSE/BETTER_____

DO YOU HAVE PAIN DURING ___AM___PM ___WORK _____HOME ____SLEEP ____RISING____ACTIVITY

INITIAL CAUSE OF PAIN?_____

PREVIOUS MEDICAL OR CHIROPRACTIC HISTORY_____

DATE OF LAST VISIT_____

DOCTOR NAME_____

MEDICAL HISTORY

BROKEN BONES_____
HOSPITALIZATION_____
SURGERIES_____
_____
SPRAINS/STRAINS_____

DRUG ALLERGIES_____
LIST OF OTHER MEDICAL CONDITIONS_____
_____

EXERCISE YES/ NO _____DAYS PER WEEK

OTHER ACTIVITIES_____

_____

NOTES_____

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Please list your desired fitness goals:

Desired Body Fat: ____ %

Desired Weight: _____ (lbs)

How many times a week do you plan on exercising?

Please check the equipment that you have access to:

Free Weights_____

Machines_____

Swiss/Exercise Ball_____

Medicine Ball_____

Balance Board_____

Slant Bench_____

Cables_____

Aerobics Step_____

Balance Disk_____

Elastic Tubing/Bands_____

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