2718 University Ave SE
Minneapolis MN 55414
612-492-1335
wholelifechiro.biz

WHOLE *LIFE* CHIROPRACTIC

Dr. Nicole Kilgo, D.C.

PATIENT INFORMATION

Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Cell Phone:_____

Work or Home Phone:_____ May we contact you via text messaging? Yes No

Birth Date:_____ Age:_____ Sex/Preferred Pronoun: Female Male They/Them

Circle one: Married Single Widowed Divorced Separated Monogomous Relationship

Email Address:_____ May we contact you via email? Yes No

Emergency Contact:_____ Phone:_____

Sports/Activities you participate in:_____

_____

Spouse/Children/family activities:_____

_____

Have you had previous chiropractic care? Yes No If yes, where?_____

Who referred you to this office?_____ Relationship:_____

Reason for consulting this office (circle all that apply): Pain Sports Injury Auto Accident Personal Injury
Work Related Injury Interested in Nutrition Obtain Optimal Health Other:_____

Describe your symptoms:_____

_____

Date of onset:_____ Have you had x-rays/MRI/CT on area? Yes No

Describe pain (circle all that apply): Deep Superficial Dull Sharp Achy Throbbing Stabbing Shooting Burning

What percent of the day do you have pain? 0-25% 26-50% 51-75% 76-100%

Have you had this problem in the past? Yes No If yes, what helped?_____

When do you feel best? Morning Afternoon Evening Worst? Morning Afternoon Evening

Have you seen anyone else for this condition? Yes No

If yes, who? MD Physical Therapist Chiropractic Athletic Trainer other:

What was their diagnosis?_____

Have you done any self-treat for this condition? Ice Heat Stretching Medication Massage

Severity of pain today on a scale of 1-10?_____ At time of injury?_____ Average since?_____

2718 University Ave SE
Minneapolis MN 55414
612-492-1335
wholelifechiro.biz

WHOLE *LIFE* CHIROPRACTIC

Dr. Nicole Kilgo, D.C.

PATIENT INFORMATION CONTINUED

Have you had injuries in the past? Please include all auto accidents, falls, sports trauma, etc and dates: _____

_____

Have you had any surgeries or hospitalizations? Please list (approx.) dates as well: _____

_____

Please list any diseases and dates_____

_____

Please list any medications you are currently taking including dosage: _____

_____

Please list any supplements you are currently taking: _____

_____

Do you drink/eat dairy? YES NO Do you eat/drink gluten? YES NO

Do you eat fast food? YES NO Times/week?

How often do you drink alcohol? Never Rarely (1x/mo) Occasionally (1x/wk) Frequently (2-3x/wk) Excessive (6-7x/wk)

How often do you exercise? Daily Frequently Intermittently Occasionally Never

Do you smoke? Yes No If yes, How much? _____

How old is your mattress? _____ years

What position do you sleep in? Back Stomach Side with legs together Side with top leg higher

Describe your daily work duties (including those inside the home):_____

_____

How many hours per week do you work? _____ How many hours do you sit per day? _____

I have read and reviewed the information contained herein and represent that it is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment.

_____ _____

Patient Signature (Parent or Guardian if applicable) (Date)

2718 University Ave SE
Minneapolis MN 55414
612-492-1335
wholelifechiro.biz

WHOLE *LIFE* CHIROPRACTIC

Dr. Nicole Kilgo, D.C.

FAMILY HEALTH HISTORY

Name:_____ Date:_____

Select all choices that apply to your family (do not include relations by marriage)

	Mother	Father	Siblings	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased (list cause of death)								
Arthritis								
Cancer- type								
Depression								
Diabetes								
Headaches								
Heart Attack/Disease								
High Blood Pressure								
Multiple Sclerosis								
Osteoporosis								
Stroke								
Thyroid Disease								

Signature:_____