CONFIDENTIAL

ROCKHILL CHIROPRACTIC & ACUPUNCTURE
305 Ft. Riley Blvd. • Manhattan, KS 66502
(785) 587-0300 • drkris401@gmail.com

Patient Health History

Today's Date ___/___/___ **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name** _____

Last Name_____ **Middle Name**_____ **Suffix**_____

Address 1 _____

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

Primary Phone_____ **Work Phone** _____

Mobile Phone_____ **SSN**_____(Optional)

Home Email _____ **Work Email**_____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*
❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth ___/___/___ **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Number of Children_____ **Ages**_____

Employment Status *(check one)*
❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____**Employer**_____

Employer Address_____

Race *(check one)*
❑ White ❑ Black/African American ❑ Hispanic ❑ Asian ❑ Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*
❑ English ❑ Spanish ❑ I choose not to specify ❑ Other

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very interested*

ROCKHILL CHIROPRACTIC & ACUPUNCTURE
HEALTH QUESTIONNAIRE

Current medications, including dosage if known.
If there are no current medications, check here: ❑

1)_____ 3) _____

2)_____ 4) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1)_____ 3) _____

2)_____ 4) _____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe:_____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0% ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes:_____

Have you had an X-ray or CT scan or MRI of your spine in the past 28 days? ❑ Yes ❑ No

Height:_____ inches **Weight:**_____ pounds **BP:**_____/_____

Whom should we thank for referring you to our clinic?_____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS_____

_____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION_____

_____

Have you ever been under Chiropractic Care? ❑ Yes ❑ No *Doctor's Name* _____

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What activities aggravate your condition? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other _____

Please circle the number that best describes your pain 0 1 2 3 4 5 6 7 8 9 10
No Pain Medium Severe

How would you describe your pain? (dull, achy, sharp, numb, stiff) _____

How long has it been since you really felt good? _____

Have you been treated for any health conditions by a medical doctor in the last year? ❑ Yes ❑ No

If yes, for what condition?_____ Name of Doctor:_____

Have you had any x-rays in the last year?_____ If yes, why? _____

Name _____

CONFIDENTIAL

ROCKHILL CHIROPRACTIC & ACUPUNCTURE
HEALTH QUESTIONNAIRE

MEDICAL HISTORY *(If any of the following are relevant to **your** medical history, please check the accompanying box.)*

❑ CANCER	❑ GERMAN MEASLES	❑ DIZZINESS	❑ ASTHMA
❑ POLIO	❑ VENEREAL DISEASE	❑ ARTHRITIS	❑ DIGESTIVE DISORDERS
❑ TUBERCULOSIS	❑ MUSCULAR DYSTROPHY	❑ NEURITIS	❑ SINUS TROUBLE
❑ HIGH BLOOD PRESSURE	❑ MULTIPLE SCLEROSIS	❑ RHEUMATISM	❑ BACKACHES
❑ HEART TROUBLE	❑ CONVULSIONS	❑ RHEUMATIC FEVER	❑ NUMBNESS
❑ DIABETES	❑ EPILEPSY	❑ SCARLET FEVER	❑ ANEMIA
❑ HEPATITIS	❑ CONCUSSION	❑ NERVOUSNESS	

Which of the following MOST CLOSELY matches your current health goals?

❑ I am only interested in getting rid of my symptoms.

❑ I am interested in fixing the underlying cause of my health problems.

❑ I am interested in being as healthy as I can be, and take an active interest in my health.

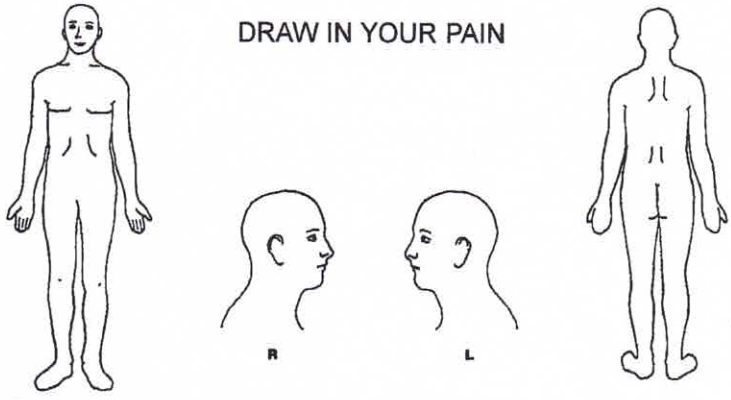
DESCRIBE THE OPERATIONS YOU'VE HAD: _____ WHEN?_____

ARE YOU PREGNANT? ❑ Yes ❑ No # PREGNANCIES_____ # CHILDREN_____

WAS THE DELIVERY DIFFICULT? _____

CONFIDENTIAL

DRAW IN YOUR PAIN



INSURANCE INFORMATION

Ins Co: _____

Insured: _____

I hereby authorize Rockhill Wellness Center, LLC to release any information necessary to process this claim and ASSIGN ALL BENEFITS payable directly to the doctor.

Signature _____

Guardian
Signature (If minor) _____

WORKERS COMPENSATION

Date of Injury:_____

Employer Name & Address:

_____

_____

_____

_____

I authorize payment of medical benefits to Rockhill Wellness Center, LLC.

Signature _____

AUTO ACCIDENT

Date of Accident: _____

Insurance Name & Address:

_____

_____

_____

_____

I authorize payment of medical benefits to Rockhill Wellness Center, LLC.

Signature _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. The statements made above are accurate to the best of my recollection and knowledge and I agree to allow this office to examine me for further evaluation and treatment.

PATIENT'S SIGNATURE_____ DATE_____

SPOUSE'S OR GUARDIAN'S SIGNATURE_____ DATE_____