Welcome to Kachinsky Family Chiropractic

We would like to extend a warm and personal welcome to you. Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available, so that you, and your family, can enjoy an **active and healthy life.** We will be working together to **help you, and your family, reach your health and wellness goals.**

If you have any questions about your chiropractic care, don't ever hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your ***Doctor's Report.*** *Please read and complete the following forms and return them to the front desk on the day of your appointment. Thank you for giving us the opportunity to serve you.*

At *Kachinsky Family Chiropractic* our purpose is to serve both God and humanity, by helping families achieve their optimum, God-given potential, for health and well-being of the body, mind and spirit, through education, empowerment and principled chiropractic care.

Thus, we are committed to providing the highest quality chiropractic care to improve the lives of our patients, and change our society's current healthcare paradigm.

Your attitude about your health is as important to us as is the specific reason you've consulted our office. Below are four prevalent health attitudes.

Please check the health attitude that most closely reflects your current personal values:

- **TREATMENT ONLY:** I only consult my doctor when I have an ache or pain and discontinue care as soon as it has cleared up.
- **PREVENTION:** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from reoccurring.
- **MAINTAINING HEALTH:** I'm conscience about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- **FAMILY HEALTH:** I take an active part in assisting, informing and maintaining health with my family. I'm concerned with the long-term effects of good health.

Many of our patients are interested in changing the way they currently view their health. Please circle any of the health attitudes above to which you may aspire.

Thank you!

You had a choice, and you chose us.

We look forward to a healthy relationship with you.

KACHINSKY FAMILY CHIROPRACTIC

PERSONAL HEALTH HISTORY
WELCOME TO OUR FAMILY!

Name _____ Date _____Patient#_____
Address_____City/State/Zip_____
Date of Birth _____ Social Security Number_____
Home Phone#_____Cell#_____Work#_____
Marital Status S M D W Email address_____ Can we email health info: Y N
Spouse's Name & Age_____ Spouse's Occupation_____
Children's Names & Ages_____
_____
Name of Employer_____ Occupation_____
Hobbies_____
Who Referred You?_____
Name of Parent or Guardian _____

Name of previous Chiropractors? _____
When was your last visit? _____
For how long were you receiving Chiropractic adjustments? _____
Reason for coming in_____
What accidents have you had (ex. Bicycle, car, motorcycle, sports, slips/falls) at work or at home(include dates):
_____
Were you ever knocked unconscious? _____
What fractures or broken bones have you had? (include dates) _____
_____

SURGERY:
What major surgery have you had? (include dates)_____
_____
What minor surgery have you had? (tonsillectomy, appendectomy, wart/cyst removal, dental extraction)
(include dates)_____

MEDICATION:

Present Prescription Drugs	Past Prescription Drugs	Over-The-Counter (aspirin, cold tablets, cough syrup)
_____	_____	
_____	_____	_____
_____	_____	_____

THERAPY:
Are you presently under any therapeutic care? (what type)_____
What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc., (include dates):__
_____

YOUR BIRTH RECORD:
Type of birth? (Vaginal, Cesarean, etc.)_____
Any complications during your mother's pregnancy or during your birth? _____
Any complications after your birth?_____

CURRENT HEALTH:
How would you describe your current health?_____ Your family's current health? _____
Describe your: Vision _____ Hearing _____ Coordination _____
Do you use any of the following: Tobacco Alcohol Coffee/Tea Regular Cola Diet Cola Milk
Level of stress in your life: Mild Moderate Extreme 1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following: **Bottled Drinking Water:** ( ) No ( ) Yes
Vitamins: ( ) No ( ) Yes **Health Food Products** (organic products, etc.) ( ) No ( ) Yes

Past Medical History (Please list any past medical history)_____
_____
_____

FINANCIAL INFORMATION:

Who is responsible for this account? _____
What method of payment will you be using? **Ins Cash Check** MC/Visa/Discover/AmEx Other_____
Name of Primary Insurance company _____ Policy #_____
Insured's Date of Birth _____ Do you have secondary insurance? ( ) Yes ( ) No
Name of Secondary Insurance _____ Policy# _____

Please check any of the following that give you difficulty or you have had recently

___**Headaches 784.0**	___Fainting 780.2	___Shortness of breath 786.0	___Asthma 493.9
___Shooting head pains 784.0	___Loss of balance 781.2	___Menstrual Cramp/Pain 625	___Constipation 564.0
___**Sinus Trouble 473.9**	___Ringing in the ears 388.3	___Heart attack 410.9	___Kidney Trouble 593.9
___**Neck Pain 723.1**	___Blurred vision 368.0	___Low blood pressure 458.9	___Loss of taste 781.1
___Allergies 995.3	___Lights bother eyes 368.13	___High blood pressure 401.9	___Inflammation of throat 462
___Muscle Spasms in neck 781	___Stomach trouble 789	___Anemia 285.9	___Diabetes 250.0
___Grinding in neck 719.4	___Nerves/Nervousness 799.2	___menstrual Irregularity 626	___Thyroid trouble 246.9
___Shoulder/arm tight 728.85	___Inner Tension 799.2	___Sleeping Problems 780.5	___Painful Joints 719.4
___Shoulder/arm pain 719.4	___Irritability 799.2	___Pain in legs/feet 719.4	___Swollen joints 782.3
___Pins & Needles in arms 782	___Indigestion 536.8	___**Hip Pain** 719.45	___Pins and needles in leg 782
___**Numbness in arms/hands 782**	___**Low back pain 724.2**	___Gall bladder trouble 579	___Swollen ankles 782.3
___Mid-back pain 724.1	___Cold hands 782	___Loss of Smell 781.1	___Cold feet 782
___**Fatigue 780.7**	___**Numbness in legs/feet 782**	___Intestinal Gas 787.3	___Facial twitch 781
___ **Depression 311.0**	___Tonsillitis 784	___Hay Fever 477.8	___Loss of Memory
___Dizziness 780.4	___Prostate Trouble 601.4	___Hernia 550.1	___Facial pain 784.0
___Spinal curvature 737.43	___Bed wetting 788.3	___Stroke 436.0	___Jaw pain (TMJ) 525.9
___Earache	___Cancer	___Arthritis 716.96	___Ulcers 534.9
___Seizures	___Ear infection	___Other	

PEDIATRIC PATIENTS ONLY:

Authorization for Care of a Minor:

I hereby agree to allow Kachinsky Family Chiropractic to administer care to my son/daughter, as they may deem necessary. I clearly understand and agree that I am personally responsible for payment for all fees charged by Kachinsky Family Chiropractic.

Name of Child/Minor: _____

Signature of Parent/Guardian: _____ Date:_____

ORIGIN OF YOUR SUBLUXATION

Which pain or condition you have checked is the worst? _____

Many of our patients have had literally dozens of stresses that can cause subluxations. We would like to discover any of yours. Please list stresses regardless of severity. Write N/A if a question does not apply.

1. When was your most recent stress or strain at work? _____
   a. Was treatment received? **YES / NO** If yes, where? What type of treatment?_____
      _____
   b. When was the one before that?_____
   c. What types of jobs have you done? _____

2. What sports or recreational activities have you been involved in? _____
   _____
   a. When was your most recent stress or strain during your activity? _____
      _____
   b. Was treatment received? **YES/NO** If yes, where? What type of treatment? _____
      _____
   c. When was the one before that? _____

3. When was your most recent auto accident? _____
   a. Speed: _____
   b. **FRONT, SIDE, or REAR-END** collision?
   c. Was treatment received? **YES / NO** If yes, where? What type of treatment? _____
      _____
   d. Please list dates of any other accidents._____

4. Is there any other injury to your spine or nervous system, minor or major? _____
   _____