Kruse – Manley Clinic of Chiropractic
4716 Morningside Ave. ~ Sioux City, IA 51106

New Patient Information

Date: ____ / ____ / ____

Name: ____Middle Initial _____ Birthdate: ____ / ____ / ____ Age: _____

Nickname __________________ □ Married □ Single □ Divorced □ Widowed No. of Children ___ SSN: _____________

Street Address: ____ □ Male □ Female

City: ___________________________________ State: _________________________ Zip: ________________________

Telephone: Home: ________________________ Work: _________________________ Cell: ______________________

Email Address: ____ Occupation: __________________________________

Employer: ____ Phone: ________________________________

Spouse's Name: _______________________________ Spouse's Employer: _____________________________________

Emergency contact: _____________________________ Relation: ___________________ Phone: _________________

Whom may we thank for referring you to our office? ____

If not referred, how did you choose us? (yellow pages, internet, radio, television, insurance, etc.) ___________________________

Reason for Visit

Please explain the pain & its location: ____

____

Explain what happened:____

When did your condition begin? _____ / ______ / ______ Is this condition getting worse? □ Yes □ No

Have you had similar conditions in the past? □ Yes □ No If yes, explain: ______________________________________

____

Have you been treated by a Medical Physician for this condition: □ Yes □ No Whom? ___________________________

Have you ever been treated by a Chiropractor before? □ Yes □ No Whom? __________________________________

More on back ▶ ▶ ▶

Health History

Do you have or have you ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	**Y N** Heart Surgery/Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+/AIDS	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema/Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes/Tuberculosis	**Y N** Difficulty Breathing	**Y N** Irritable Bowel Syn.
Y N Lower Back Problems	**Y N** Artificial Bones/Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:
____

Please list anything you may be allergic to: ____

List previous surgeries/treatments & dates: ____

List any past serious accidents & dates: ____

Do you smoke? □ No □Yes / How much? ______________ How long?____________________

Are you currently taking: □ Pain Killers □ Muscle Relaxers □ Ibuprofen/Aspirin □ Other ______

Please list any **medications** or **supplements** that you are taking for your health? What are they for?

____
____
____
____
____
____

Does anyone in your family have any history of the following diseases/conditions? If so, whom?

Y N Heart Disease ______________________	**Y N** Cancer______________________________
Y N Diabetes ___________________________	**Y N** Rheumatoid Arthritis__________________
Y N MS/Alzheimer's ____________________	**Y N** Parkinson's _________________________
Y N Asthma/Allergies ___________________	**Y N** Eczema/Psoriasis _____________________
Y N Thyroid Problems ___________________	**Y N** Autoimmune Diseases _________________
Y N Lactose Intolerance _________________	**Y N** Wheat Intolerance ____________________

Other (please list) ____

For Women: Are you taking Birth Control? □ Yes □ No If so, what type? (pill, IUD, etc) _______
Are you pregnant? □ No □Yes/How long?__________ Currently Nursing? □ Yes □ No

Pain Chart

Please indicate areas of pain or discomfort using the appropriate symbols from the chart below:

Numbness	Pins & Needles	Burning	Aching	Stabbing
NNNN	PPPP	BBBB	AAAA	SSSS

Doctor's Notes

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information that I have provided.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize Kruse-Manley Clinic of Chiropractic to release any information required to process insurance claims. I agree to be financially responsible for any services submitted to my insurance company if they are deemed to be a non-covered benefit, not medically necessary, or if my insurance benefits have been maxed out.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

Signature ______________________________ Date _____/_____/_____

☐Adult Patient ☐Parent or Guardian ☐Spouse