

1. PAYMENT is due at the time of service, unless other arrangements have been made.
2. An INSURANCE CONTRACT is between the patient and the patient's insurance company; therefore, it is the responsibility of the patient to keep the account current.
3. Patients involved in LITIGATION (lawsuits) are, as others, responsible for their service here at the clinic.
4. We reserve the right to BILL FOR MISSED APPOINTMENTS.
5. Personal cleanliness is requested due to the close interpersonal nature of this work.
6. SMOKING IS PROHIBITED.

PATIENT NAME			HOME PHONE		WORK PHONE	
STREET ADDRESS			CITY		STATE	ZIP
BIRTHDATE	AGE	SOCIAL SECURITY #		DRIVERS LICENSE#	BY WHOM WERE YOU REFERRED	
OCCUPATION		EMPLOYER		EMPLOYER'S ADDRESS		
SPOUSE'S NAME		SPOUSE'S BIRTHDATE	SPOUSE'S SOCIAL SECURITY #		SPOUSE'S WORK PHONE	
IN THE EVENT OF AN EMERGENCY, WHOM SHOULD WE NOTIFY?			RELATIONSHIP TO PATIENT		DAYTIME PHONE	

My signature is an acknowledgement that I have read the policy above and agree to abide by the same and authorize the office of Paul W. Kerkhoff, D.C. to treat and/or release any medical information necessary to process this claim and request payment of benefits of either to myself or to the party who accepts assignment below.

PATIENT SIGNATURE:	DATE:	WITNESS SIGNATURE:
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IF PATIENT IS A MINOR: Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

GUARDIAN SIGNATURE:	DATE:	WITNESS SIGNATURE:
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PLEASE ALLOW OUR OFFICE TO PHOTOCOPY ANY INSURANCE CARD (S)

SUBJECTIVE COMPLAINTS

Explain WHEN and HOW it happened: _____

COMPLIANTS/SYMPTOMS: Come and go Came on gradually

Symptoms have persisted for: Hours 1 day Days Weeks Months Years

Symptoms developed from: Work-related injury Auto accident Injury other than work/auto

DESCRIBE COMPLAINTS: PLEASE BE SPECIFIC

Involving Neck & Head: _____

Involving Mid-back/Shoulders/Arms & Hands: _____

Involving Low back/Hips/Legs & Feet: _____

Give name(s) of doctor(s) previously seen for this present complaint: _____

What medications are your presently taking? _____

For what condition _____

What activities make condition WORST? _____

For what condition _____

Symptoms are WORSE in: AM Midday PM Symptoms are BETTER in AM Midday PM

Symptoms do not change with time of day Yes No

Have you ever had this condition/problem before: Yes No If yes, when? _____

Give date of last X-rays: _____ What body parts were X-rayed? _____

List any surgeries you have had: _____

List any known allergies to medications: _____

FAMILY HISTORY (example Cancer/Diabetes, Heart problems/Back or neck problems)

Father: _____ Brother/Brothers: _____

Mother: _____ Sister/Sisters: _____

Please check (indicate with a "C", "P", or "N") the appropriate box for any of the following symptoms, which you now have or have had previously. We want all the facts about your health before we accept your case.

THIS IS A CONFIDENTIAL HEALTH REPORT.

C = CURRENTLY HAVE

P = PAST CONDITION

N = NEVER HAD

C	P	N	GENERAL	C	P	N	GASTRO-INTESTINAL	C	P	N	CARDIO-VASCULAR
			Allergy				Colitis				Hardening of arteries
			Chills				Constipation				High blood pressure
			Convulsion				Diarrhea				Low blood pressure
			Dizziness				Difficult digestion				Pain over heart
			Fainting				Gall bladder trouble				Poor circulation
			Fatigue				Hemorrhoids				Rapid heart beat
			Headache				Jaundice				Slow heart beat
			Loss of sleep				Liver trouble				Swelling of ankles
			Loss of weight				Nausea				GENITO-URINARY
			Nervousness/depression				Pain over stomach				Bed wetting
			Neuralgia				Poor appetite				Blood in urine
			Numbness				Vomiting				Frequent urination
			Tremors				Vomiting of blood				Inability to control kidneys
			MUSCLE & JOINT				EYES, EARS, NOSE & THROAT				Kidney stones/infection
			Arthritis				Asthma				Painful urination
			Bursitis				Colds				Prostate trouble
			Foot trouble				Deafness				Pus in urine
			Hernia				Dental decay				RESPIRATORY
			Low back pain				Earache				Chest pain
			Pain between shoulders				Ear discharge				Chronic cough
			PAIN OR NUMBNESS IN:				Ear noises				Difficult breathing
			Shoulders				Enlarged glands				Spitting up blood
			Arms				Eye pain				Spitting up phlegm
			Elbows				Failing vision				
			Hands				Gum trouble				CHECK THE FOLLOWING
			Legs				Hoarseness				CONDITIONS YOU HAVE HAD
			Knees				Nasal obstruction			Alcoholism	Heart disease
			Hips				Nosebleeds			Anemia	Measles
			Feet				Sinus infection			Appendicitis	Miscarriage
			Sciatica				Sore throat			Arthritis	Multiple sclerosis
			Spinal curvature				Tonsillitis			Cancer	Mumps
			Swollen joints				FOR WOMEN ONLY			Chorea	Pleurisy
			SKIN				Congested breast			Cold sores	Pneumonia
			Bruise easily				Cramps or backache			Diabetes	Polio
			Dryness				Excessive menstrual flow			Diphtheria	Rheumatic fever
			Hives or allergy				Hot flashes			Eczema	Stroke
			Itching				Irregular cycle			Emphysema	Tuberculosis
			Skin eruptions (rash)				Menopausal symptoms			Epilepsy	Ulcers
			Varicose veins				Painful menstruation			Goiter	Venereal disease
							Vaginal discharge			Gout	Whooping cough
					Yes	No	Are you pregnant?				
				Date of onset of last Menstrual cycle: _____							

Who is your primary Physician: _____ Telephone: _____