Dr. Kent Hill Chiropractic

WELCOME

Name: (first)_____(mi)_____(last)_____

Address:_____

(city)_____(state)_____(zip)_____

☐ M ☐ F Birthdate:____/_____/_____ Age:_____ Height:_____Weight:_____

Home Number:(___)_____ Work:(___)_____Cell:(___)_____

Employer/School:_____Occupation:_____

Married: ☐ No ☐ Yes Spouse's Name:_____

Whom may we thank for your referral:_____

Insurance company:_____

Policy#:_____ Group#:_____

Please give a copy of your card to receptionist

IN CASE OF EMERGENCY CONTACT:_____

Phone#:(___)_____ Relationship:_____

Is this condition due to an accident? ☐ Yes ☐ No

Type of accident ☐ Auto ☐ Work ☐ Home

Please mark your areas of pain on the figures below:

Describe what it feels like

☐ Sharp ☐ stabbing ☐ dull ☐ ache ☐ tightness

☐ Pulling ☐ burning ☐ numbness ☐ tingling

☐ Pins & needles ☐ throbbing

☐ Other:_____

Do your symptoms radiate or shoot to other areas?
If so, where:_____

On the following scale please mark the intensity/severity

0__/__/__/__/__/__/__/__/__/__/___/__10
1 2 3 4 5 6 7 8 9 10

When did symptoms begin?_____

Has it gotten worse since then? ☐ Yes ☐ No