3631 South 6th Street, Suite B
Springfield, IL 62703
(217) 391-5446

Kevin A Imhoff, D.C.
Joseph R Barron, D.C.

Patient Information

Date: ______________________

Patient Name: ______________________________
(First, Middle, Last)

Age: ________ Date of Birth: ______________

Name by Which You Wish to be Addressed: ______________ Sex: ☐ Male ☐ Female

Address: ______________________ City: ______________ State: ________

Zip Code: __________ Home Phone #: ______________ Cell Phone #: ______________

Social Security Number: ______________ Driver's License Number: ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed E-mail Address: ______________

Primary Care Physician's Name: ______________ Date of Last Physical Exam: ______________

How were you referred to the office? ☐ By a Physician ☐ Yellow Pages ☐ Lecture ☐ Exhibit ☐ By a Patient

Please print the name of reference source ______________________________

Are you a FitClub Member? ☐ Yes ☐ No

Insurance Carrier: ______________________ Group #: ______________

Employment Information

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-Time Student ☐ Part-Time Student ☐ Other __________

Employer: ______________________ Occupation: ______________________

Address: ______________________ Phone #: ______________

Spouse Information

Spouse Name: ______________________ Date of Birth: ______________

Occupation: ______________ Employer: ______________ Phone #: ______________

Person Responsible for Payment (if other than Patient)

Name: ______________________ Date of Birth: ______________

Relationship to Patient: ______________

Address: ______________________ Phone #: ______________

Emergency Contact Person

Name: ______________ Phone #: ______________ Relationship to Patient: ______________

Past Health History

Hospitalizations - please list any and all hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Surgeries - please list any and all surgeries

Type	Age Performed	Date Performed	Place of Surgery (area of body) and Physician	Left/Right or Bilateral

Injuries - please list any and all injuries

Year	Description of Injury and Areas injured

Smoking Status ☐ Current Every Day Smoker ☐ Current Periodic Smoker: How often ______________
☐ Former Smoker: Year started____________ Year Quit ____________ ☐ Never Smoker
☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Lives with Smoker

Type and Quality of Tobacco

☐ Chews Number of pouches per week? ____________________
☐ Cigarettes Number of packs/day? ____________________
☐ Cigars Number per week?____________________
☐ Dips Cans per week? ____________________
☐ Pipe Number of Pipefuls per day? ____________________

Present Complaints

1. Chief Complaint and Location:____

____

How did this occur: ☐ Injury at work ☐ Auto Accident ☐ Accident (Fall, etc.)
☐ Other, Please describe: ____
Date of injury and/or onset of symptoms: ____
Does your pain radiate (travel) or is it localized? If it radiates, please describe where it travels from and to.____________

____

Does your pain occur at work, home, during exercise, AM, PM, etc.? ____________________
Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 0 1 2 3 4 5 6 7 8 9 10
Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of time it occurs. ____
Have your symptoms gotten better, stayed the same, or gotten worse? ____________________.
What treatments have you tried yourself for this condition? Have they helped or made your pain worse? ____________

____

2. Second Complaint and Location:____

____

How did this occur: ☐ Injury at work ☐ Auto Accident ☐ Accident (Fall, etc.)
☐ Other, Please describe: ____
Date of injury and/or onset of symptoms: ____
Does your pain radiate (travel) or is it localized? If it radiates, please describe where it travels from and to.____________

____

Does your pain occur at work, home, during exercise, AM, PM, etc.?____________________
Please rate the intensity of your pain. 0=No Pain, 10=Excruciating Pain. Circle 1 2 3 4 5 6 7 8 9 10
Is your pain constant, intermittent, or constant w/ ranging degrees of intensity? If intermittent indicate what % (0-100) of time it occurs. ____
Have your symptoms gotten better, stayed the same, or gotten worse? ____________________.
What treatments have you tried yourself for this condition? Have they helped or made your pain worse? ____________

____

Previous Treatment of above Complaint(s)

1. Physician Name: ____________________ Type of Physician:____________________
Date(s) of Visit (s) :____________________ Diagnosis: ____________________
Type of Treatment :____________________ Result of Treatment: ____________________
2. Physician Name: ____________________ Type of Physician:____________________
Date(s) of Visit (s): ____________________ Diagnosis: ____________________
Type of Treatment: ____________________ Result of Treatment: ____________________
3. Physician Name: ____________________ Type of Physician:____________________
Date(s) of Visit (s): ____________________ Diagnosis: ____________________
Type of Treatment: ____________________ Result of Treatment: ____________________

A=Ache B=Burning D=Dull I=Itching N=Numbness P=Pins & Needles S=Stabbing SH=Sharp

T=Tender TH= Throbbing TT= Tightness O=Other________________________________

Use the above letters to indicate type and location of pain, discomfort and sensations.

In reference to the following descriptions, check the appropriate box as to what activities increase or decrease your symptoms

	Increase	Decrease		Increase	Decrease
With a Cough/Sneeze	☐	☐	Lying flat on Back	☐	☐
Sitting Down	☐	☐	Lying on Stomach	☐	☐
Driving an Automobile	☐	☐	Lying on Side w/ knees bent	☐	☐
Bending over to Brush Teeth	☐	☐	Strain w/ Bowel Movement	☐	☐
Walking	☐	☐	Upon awakening	☐	☐
At the End of the Day	☐	☐	Middle of the Night	☐	☐

Please list any other activities, etc. which increase or decrease your symptoms not listed above.________________________________

____

____

Medications - List any and all medications you are presently taking

Name of Medication	Dosage	Times Per Day	Reason for Taking

Vitamins/Supplements - List any and all vitamins/supplements you are presently taking

Name of Vitamin/Supplement	Dosage	Times per Day	Reason for Taking

Allergies: (Medications, food, other)	**Type of Reaction**

REVIEW OF SYSTEMS

The items below may relate to your current condition. In the space in front of each item, place a "C" if you CURRENTLY have the problem and an "P" if you HAD the problem in the past. Leave space blank if you NEVER had the problem.

GENERAL

1. ______ Fever
2. ______ Chills
3. ______ Night Sweats
4. ______ Loss of Sleep/Insomnia
5. ______ Fatigue
6. ______ Nervousness
7. ______ Weight Loss or Gain
8. ______ Allergies
9. ______ Bleeding Problems
10. ______ Anemia
11. ______ Diabetes
12. ______ Cancer
13. ______ Depression
14. ______ Alcoholism
15. ______ Anorexia
16. ______ Bulimia
17. ______ Bronchitis
18. ______ Cataracts
19. ______ Emphysema
20. ______ Water Retention
21. ______ Glaucoma
22. ______ Goiter
23. ______ Gout
24. ______ Hepatitis
25. ______ High Cholesterol
26. ______ Measles
27. ______ Migraine Headaches
28. ______ Mononucleosis
29. ______ Multiple Sclerosis
30. ______ Mumps
31. ______ Polio
32. ______ Rheumatic Fever
33. ______ Scarlet Fever
34. ______ Thyroid Problems
35. ______ Typhoid fever
36. ______ Chronic Fatigue Syndrome
37. ______ Cold Sores
38. ______ Diphtheria
39. ______ Lupus
40. ______ Malaria
41. ______ Pleurisy
42. ______ Whooping Cough
43. ______ Chicken Pox

WOMEN ONLY

44. ______ Live Births #__________
45. ______ Miscarriage # _________
46. ______ Hot Flashes
47. ______ Painful Periods
48. ______ Excessive Flow
49. ______ Irregular Cycles
50. ______ Vaginal Burning/Itching
51. Date Last Period: ________________________
52. Date Last Mammogram: ________________________
53. Birth Control Type: ________________________
54. Date of Last Pap: ________________________

MEN ONLY

55. ______ Testicular Pain/Swelling
56. ______ Prostate Problems

RESPIRATORY

57. _____ Difficulty Breathing
58. _____ Chronic Cough
59. _____ Spitting Phlegm
60. _____ Spitting Blood
61. _____ Wheezing/Asthma
62. _____ Pneumonia
63. _____ Tuberculosis

CARDIOVASCULAR

64. _____ Irreg. Heartbeat Rapid or Slow
65. _____ High/ Low Blood Pressure
66. _____ Pain Over Heart
67. _____ Previous Heart Trouble
68. _____ Ankle Swelling
69. _____ Varicose Veins
70. _____ Rheumatic Fever
71. _____ Stroke
72. _____ Heart Attack
73. _____ Poor Circulation
74. _____ Pacemaker/Defibrillator
75. _____ Arteriosclerosis

GENITO-URINARY

76. _____ Frequent Urination
77. _____ Painful Urination
78. _____ Blood in Urine
79. _____ Kidney Infection
80. _____ Kidney Disease
81. _____ Urinary Infection
82. _____ Inability to Control Urination
83. _____ Difficulty Starting Urine Flow
84. _____ Get up ___ times/ night to urinate
85. _____ Breast Lump or Pain
86. _____ Sexual Difficulties
87. _____ Bedwetting
88. _____ Venereal Infection/Disease
    Type__________________
89. _____ Vaginal Infections

SKIN

90. _____ Itching
91. _____ Bruising Easily
92. _____ Change in Mole(s)
93. _____ Skin Cancer
94. _____ Dry Skin
95. _____ Eczema
96. _____ Psoriasis
97. _____ Scars/Location ______________
98. _____ Rash or Hives

NEUROLOGIC

99. ______ Weakness
100. ______ Twitching
101. ______ Tremors
102. ______ Headache
103. ______ Fainting
104. ______ Dizziness
105. ______ Convulsions
106. ______ Epilepsy
107. ______ Numbness/Tingling
108. ______ Arm/Leg Pain
109. ______ Mental Disorder

MUSCULOSKELETAL

110. _____ Neck Stiffness/Pain
111. _____ Pain Between Shoulders
112. _____ Low Back Pain
113. _____ Swollen Joints/Bursitis
114. _____ Painful Joints
115. _____ Muscle Aches/Soreness
116. _____ Spinal Curvature
117. _____ Osteoarthritis
118. _____ Rheumatoid Arthritis

EYE, EAR, NOSE, THROAT

119. _____ Hoarseness
120. _____ Poor Vison/Failing
121. _____ Pain in Eye(s)
122. _____ Gum Problems
123. _____ Nosebleeds
124. _____ Nose Problems
125. _____ Sinus Trouble
126. _____ Dental Problems
127. _____ Tonsilitis
128. _____ Tonsillectomy
129. _____ Deafness/Difficulty Hearing
130. _____ Ringing in Ears
131. _____ Sore Throat
132. _____ Swollen/Enlarg.Glands

GASTROINTESTINAL

133. _____ Leaky Gut Syndrome
134. _____ Heartburn
135. _____ Poor Appetite
136. _____ Poor Digest./Indigestion
137. _____ Difficulty Swallowing
138. _____ Belching or Gas
139. _____ Frequent Nausea
140. _____ Vomiting w/wo Blood
141. _____ Pain Over Abdomen
142. _____ Ulcer
143. _____ Black or Bloody Stools
144. _____ Liver Problems
145. _____ Gall Bladder Problems
146. _____ Jaundice
147. _____ Hernia
148. _____ Diarrhea
149. _____ Constipation
150. _____ Hemorrhoids
151. _____ Appendicitis
152. _____ Excessive Thirst
153. _____ Acid Reflux

HABITS

154. _____ Alcohol ____ #drinks/Day
155. _____ Recreational Drug Use
156. _____ Tobacco/Smoking ___#pks/Day
157. _____ Sugar/Substitutes _____ amt./Day
158. _____ Caffeinated Drinks
     #_____Cups/Day
     #_____Cans/Day

FAMILY HEALTH HISTORY

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER (S)		SISTER (S)		CHILDREN	
	Age ____	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___
Allergies									
Arthritis									
Asthma-hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc problem									
Emotional Problems									
Emphysema									
Epilepsy									
Gastrointestinal disorders									
Headaches									
Heart Disease									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Disease									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Syphilis									
Other									
Other									
Other									

If any of the above family members are deceased, please list their age at death and cause: ____________________

____

____

Consent to Treatment

I voluntarily consent to receive chiropractic and health care services that may include diagnostic procedures, examinations and treatment.

Our doctors will discuss your health history, perform an examination and discuss recommendations with you. They only accept cases based on examination findings and diagnostic tests. There are no guarantees or promises of improvement or complete recovery. We will ask you many questions pertaining to your health, pain, and present condition. Please give the doctor as much information as you can remember.

Your signature below fully authorizes our staff and doctors to perform any examination, diagnostic test and or treatment we may consider medically necessary, and to release all information pertinent to your health, insurance, or benefits to any and all applicable parties on your behalf.

Financial Responsibility and Assignment of Benefits

I agree to pay all services and or fees accrued on my account, including but not limited to chiropractic services, supplements, supplies, missed appointment fees, service charges and/or collection fees.

I certify that I have read this form and understand its content.

______________________________________ Date: ____________________

(Patient Signature or Other Legally Authorized Person)

Information Checked/Witnessed By: ______________________________ Date: ____________________