

Keller Clinic

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Patient Health Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ Phone (Work): _____

E-mail address _____ Date of Birth: _____ Age: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed # of Children _____

Your social security number: _____ Spouse SS# _____

Occupation: _____ Employer: _____

Spouse's Employer: _____ Referred by: _____

Have you seen a chiropractor before? Yes No Chiropractor's name: _____

Who is your primary care physician? _____

Reason for your visit today? (Please list areas of pain.) _____

Date of accident or beginning of symptoms: _____

Name of emergency contact or nearest relative not living with you and their contact information:

INSURANCE INFORMATION

Insurance company: _____ Phone: _____

Spouse's insurance company: _____ Phone: _____

Are present symptoms due to an injury? Yes No on the job Auto Accident Personal Injury

Has the accident been reported? Yes No to Worker's Comp? To Auto Carrier?

Have you retained an attorney? Yes No

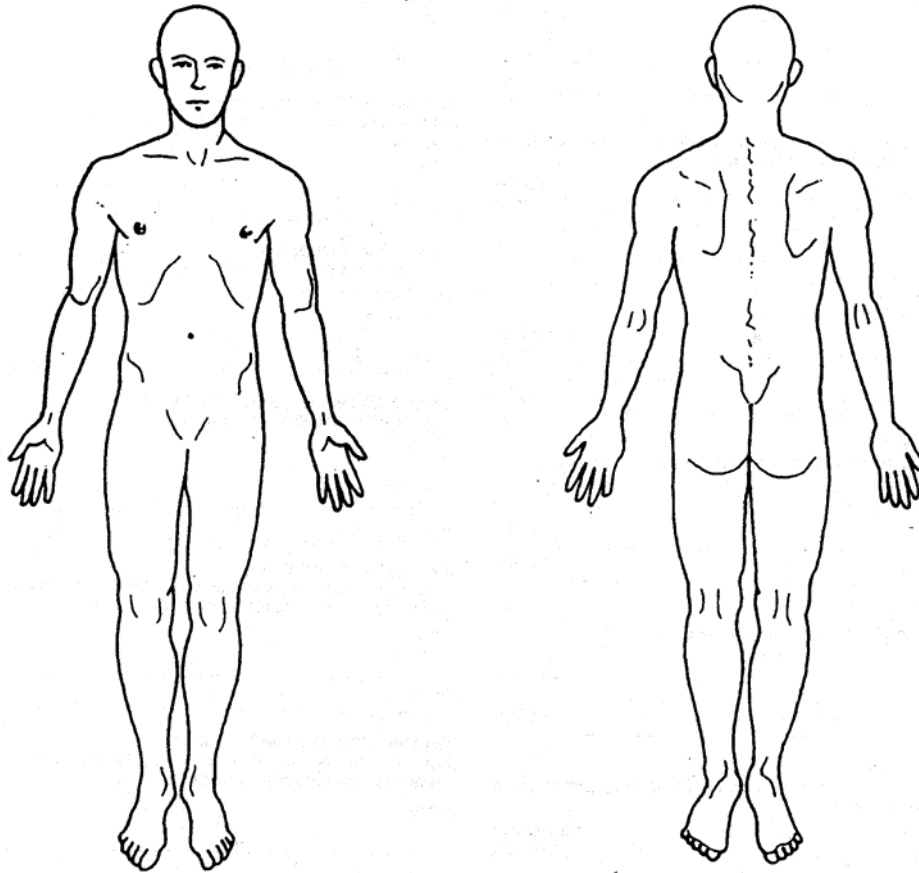
Name and phone number:

SEVERITY OF PAIN

List the area of pain and circle the number below to describe the amount of pain with "1" indicating minor Discomfort and "10" representing severe pain.

- 1. _____ 1 2 3 4 5 6 7 8 9 10
- 2. _____ 1 2 3 4 5 6 7 8 9 10
- 3. _____ 1 2 3 4 5 6 7 8 9 10
- 4. _____ 1 2 3 4 5 6 7 8 9 10
- 5. _____ 1 2 3 4 5 6 7 8 9 10

Mark the areas on your body where you feel your pain. Use appropriate symbols. If pain radiates, draw with an arrow from where it starts to where it stops.



Ache>>> Burning XXX Numbness OOO Pins & Needles +++ Stabbing /// Throbbing ~~~

Please list any concerns about your symptoms and anything else you would like the doctor to know:

List any accidents, injuries, falls and dates.

__ Car: _____

__ Sports: _____

__ School: _____

__ Other: _____

List any broken bones or dislocations:

Have you ever had a spinal tap or injection? __ Yes __ No

Have you ever been knocked unconscious? __ Yes __ No

Have you ever had a lapse in memory? __ Yes __ No

Have you ever had x-rays, MRI or CAT Scan of your spine? __ Yes __ No When? _____

Are you presently taking any prescription medication? __ Yes __ No If yes, please list:

Please check or place an "x" for all symptoms that currently apply to you.

General Symptoms

- Headaches
- Fever
- Night sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Loss of weight
- Allergies
- Weakness
- Twitching

Gastro-Intestinal

- Poor appetite
- Poor digestion
- Excessive hunger
- Belching or gas
- Nausea
- vomiting
- Stomach pain
- Constipation
- Diarrhea
- Hemorrhoids
- Liver trouble
- Jaundice
- Gall bladder

EENT

- Poor vision
- Pain in eyes
- Deafness
- Earache
- Ear noises
- Nosebleeds
- Sore throat
- Hoarseness
- Hay fever
- Asthma
- frequent colds
- Thyroid trouble
- Tonsillitis
- Sinus Trouble

Respiratory

- Cough
- Short of breath

Genito-Urinary

- frequent urination
- Painful urination
- Blood in urine
- Kidney infections
- Bed wetting
- Incontinence
- Prostate trouble
- Bladder infections

Muscle and Joints

- Stiff neck
- Neck pain
- Middle back pain
- Lower back pain
- Arm pain
- Arm numbness
- Hand/Wrist pain
- Hand/Wrist numbness
- Leg pain
- Leg numbness
- Swollen joints
- Painful tailbone
- Foot pain
- Spinal curvature

Cardiovascular

- Rapid heartbeat
- Slow heartbeat
- High blood pressure
- Chest pain
- Swollen ankles
- Poor circulation
- Varicose veins
- Eczema
- Stroke
- Heart attack

Skin

- Itching
- Bruise easily
- Dry skin
- Boils
- Sensitive skin
- Hives

For Women Only

- currently pregnant
- Painful Periods
- Excessive Flow
- Irregular cycles
- Cramps
- Hot flashes
- vaginal discharge
- Breast implants
- Date of last PAP: _____

Have you had any of the following? (Please check or place an "x")

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Hypertension | |

Have you had any of the following surgeries? If yes, please list date.

- | | | |
|--|---|---|
| <input type="checkbox"/> Appendectomy: _____ | <input type="checkbox"/> Hemorrhoids: _____ | <input type="checkbox"/> Stomach: _____ |
| <input type="checkbox"/> Back: _____ | <input type="checkbox"/> Hernia: _____ | <input type="checkbox"/> Thyroid: _____ |
| <input type="checkbox"/> Breast reduction: _____ | <input type="checkbox"/> Mastectomy: _____ | <input type="checkbox"/> TMJ: _____ |
| <input type="checkbox"/> Cataract: _____ | <input type="checkbox"/> Neck: _____ | <input type="checkbox"/> Tonsillectomy: _____ |
| <input type="checkbox"/> Female organs: _____ | <input type="checkbox"/> Prostate: _____ | <input type="checkbox"/> Tubes in ears: _____ |
| <input type="checkbox"/> Gall bladder: _____ | <input type="checkbox"/> Sinus: _____ | <input type="checkbox"/> Vision correction: _____ |

Family History: Has any member of your family had any of the following diseases?

- Diabetes Kidney Arthritis Heart Cancer Lung

Habits

Smoking: Packs per day _____

Alcohol: Drinks per day _____

Coffee/Tea: Cups per day _____

Vitamins/herbs (list all being taken):

Exercise: None Moderate Daily

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____