



Kimel Chiropractic Center, P.C.

Our Family Serving Yours.

Michele Kimel, D.C.
Nick Kimel, D.C.

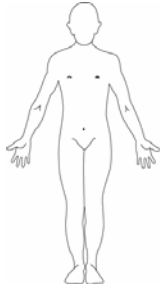
Gene Kimel, D.C.
Neta Kimel, D.C.

CASE HISTORY

Name: _____ Date: _____

List the reason for consult at this office:
Include any wellness concerns or chief complaints.

1. _____
2. _____
3. _____



Please mark your area of complaint on the body
+++ burning XXX dull ache ttt throbbing
III sharp 000 tingling

SEVERITY OF PAIN

List area complaint and rate severity from 1-10

1. _____
Best 1 2 3 4 5 6 7 8 9 10 Worst Possible
2. _____
Best 1 2 3 4 5 6 7 8 9 10 Worst Possible
3. _____
Best 1 2 3 4 5 6 7 8 9 10 Worst Possible



Past chiropractic care? Yes / No

Doctor's Name: _____

When: _____ Results: _____

Primary Medical Doctor's

Name: _____

Have you ever had X-rays taken: Yes / No

When? _____

By whom: _____

Reason: _____

Spinal Exam: _____

Lab Exam: _____

Last Physical: _____

FEMALE ONLY

Pap smear: _____

Breast Exam: _____

FAMILY HISTORY

	Diabetes	Heart	Stroke	Cancer
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Other	_____			

HABITS

Drink bottled water? Yes / No

Consume vitamins or supplements? Yes / No

Exercise Regularly? None _____ Moderate _____ Daily _____

Type of Exercise _____

Smoking Yes / No Packs per Day _____

Alcohol Yes / No How Much? _____

Coffee Yes / No How Much? _____

HEALTH HISTORY

Physical Stress

List dates of any accidents or falls.

Auto: _____ Recreational Vehicle: _____ Horse: _____

Sports: _____ School: _____ Other _____

List any broken bones (fractures) or dislocations: _____

Have you had any surgeries? _____

How many hours a day do you sit? _____ stand? _____ use a computer? _____ perform a repetitive motion? _____

Chemical Stress

List any medications you are currently on. _____

Estimate how much you spend on prescription or over-the-counter medication a year. _____

How do you rate your diet? _____

Any known exposure to toxic chemicals? _____

Emotional Stress

Does any part of your body, in particular, tense up in stressful situations? _____

Do you enjoy your work? _____

How would you rate your emotional stress level? Low _____ Medium _____ High _____

Do you suffer from any condition other than that for which you are now consulting us? _____

On a scale of 1- 10 with 1 being the least, where do you value your health care? _____



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Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please check the Now column if you have had the symptom within the past 12 months or the Past column if you ever had the condition previously.

	Now	Past		Now	Past
	N	P		N	P
Headaches___ Frequency	___	___	Vomiting	___	___
Neck Pain	___	___	Belching	___	___
Stiff Neck	___	___	Loss of Smell	___	___
Sleeping Problems	___	___	Loss of Taste	___	___
Back Pain	___	___	Diarrhea	___	___
Nervousness	___	___	Feet Cold	___	___
Tension	___	___	Hands Cold	___	___
Irritability	___	___	Arthritis	___	___
Chest Pains	___	___	Muscle Spasms	___	___
Dizziness	___	___	Frequent Colds	___	___
Shoulder/Neck/Arm Pain	___	___	Stomach Upset	___	___
Tingling in Arms	___	___	Constipation	___	___
Tingling in Legs	___	___	Cold Sweats	___	___
Numbness in Fingers	___	___	Fever	___	___
Numbness in Toes	___	___	Sinus Problems	___	___
High Blood Pressure	___	___	Diabetes	___	___
Difficulty Urinating	___	___	Hemorrhoids	___	___
Allergies	___	___	Leg Cramps	___	___
Weakness in Arms	___	___	Colitis	___	___
Weakness in Legs	___	___	Gall Bladder	___	___
Shortness of Breath	___	___	Indigestion	___	___
Fatigue	___	___	WOMEN ONLY		
Depression	___	___	Endometriosis	___	___
Lights Bother Eye	___	___	Fibroid cysts	___	___
Loss of Memory	___	___	Menstrual cramps___	___	___
Ears Ring	___	___	Excessive flow	___	___
Double Vision	___	___	Hot Flashes	___	___
Loss of Balance	___	___	Menopause	___	___
Buzzing in Ears	___	___	Irregular periods	___	___
Tremors	___	___	Miscarriage	___	___
Knee Pain	___	___	Painful periods	___	___
Swelling Joints	___	___	Pelvic pain	___	___
Shoulder Pain	___	___	Pregnant	___	___
Fainting	___	___	PMS	___	___

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the doctor for X-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees to responsibility for all bills incurred at this office.

Signature

Date