



2785 N. Ankeny Blvd.
Ste. 16
Ankeny, IA 50023
(515) 964-5000

kruegerchiro@kruegerankeny.com

PATIENT INFORMATION

Date: _____
Patient Name: _____
Address: _____

City State Zip
Home Phone: _____
Alt. Phone: _____
Fax: _____
Email: _____

Use this information for mailing?
Yes No, please ask for form

Sex: M F Age: _____
Birth date: _____

Single Married Widowed
Separated Divorced

Patient

Occupation: _____
Employer: _____
Employer
Address: _____

Employer Phone: _____

Family Members

Spouse: _____
Children
(Name/age): _____

Spouse's

Birth date: _____ SS#: _____
Occupation: _____
Employer: _____

INSURANCE INFORMATION

Who is responsible for this
account? _____
Relationship to patient: _____
Insurance Co: _____
Group #: _____
Insurer's Name: _____
Birth date: _____ SS#: _____

Is patient covered by additional insurance?
Yes No, please ask for form

ASSIGNMENT & RELEASE

I, the undersigned, certify that Krueger
Chiropractic will provide the necessary
paperwork for me to file directly with my
insurance company. I am responsible for any
charges from Krueger Chiropractic and they
must be paid at time of service unless
otherwise specified. In the case there is a
need for Krueger Chiropractic to dialogue
with my insurance company, I hereby
authorize the release of all information
necessary for completion.

Responsible Party Signature

Relationship _____ Date _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____

MEDICATIONS

ALLERGIES

SUPPLEMENTS

PAST HISTORY (Please explain all Yes's)			
Do you have or had any of these conditions?			
	Yes	No	Description
Arthritis			_____
Asthma			_____
Bleeding Disorders			_____
Cancer			_____
Diabetes			_____
Epilepsy			_____
Fractures			_____
Heart Disease			_____
High Blood Pressure			_____
High Cholesterol			_____
Kidney Disease			_____
Multiple Sclerosis			_____
Osteoporosis			_____
Parkinson's			_____
Prostate Problems			_____
Scoliosis			_____
Stroke			_____
Other _____			_____
Does/did your father, mother, brothers, sisters or children ever have:			
	Yes	No	Description
Arthritis			_____
Anemia			_____
Back Problems			_____
Cancer			_____
Diabetes			_____
Disk Problems			_____
Genetic Disease			_____
Heart Trouble			_____
Kidney Disease			_____
Osteoporosis			_____
Stroke			_____
Other _____			_____

HEALTH INFORMATION

Is this condition due to an accident? Yes No

Type of accident: Auto Work Home Date: _____

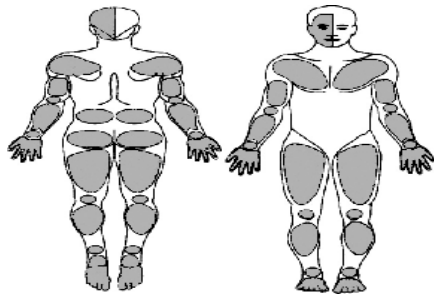
To whom have you made a report of your accident? Auto Ins. Employer
Worker Comp. Other _____

Reason for visit: _____

When did it occur? _____

Is the condition getting worse? Yes No

Mark an X on the picture where your symptoms/injuries appear:



Description:

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ____

What type of pain is it? Aching Burning Cramping
Dull Numbing Sharp
Shooting Soreness Stiffness
Swelling Throbbing Tingling
Weakness Other _____

In comparison to past injuries/conditions, is it: Mild Moderate Severe

Does it occur: Occasional (1X/month) Intermittent (1-2X/week)
Frequent (1X/week) Constant (1X/day)
Other _____

Has it been: Improving Worsening Unchanged Resolved

How did your complaints begin? Unknown Suddenly Gradually

Do you notice them worse in the: Morning Afternoon Evening
Night Always the same
Other _____

What makes your condition BETTER? _____

What makes your condition WORSE? _____