Welcome to the Offices of Drs. Knoll & Brockman

ABOUT YOU

Today's Date ____/____/_____

Name: ______________________________________

What name do you prefer we call you? ____________

Who/How are you referred to us? ________________

Home address: ______________________________

City _____________ State _________ Zip ________

Birth Date: _____/_____/______ Age: ___________

SS# (optional): _____-_____-_____ Gender: M / F

Home phone: _______________________

Work phone: _______________________

Cell phone: _______________________

E-mail address: ______________________________

Employer: ____________________________________

Marital status: Single / Married / Divorced / Widowed

Spouse's name: ______________________________

Spouse's birth date (for insurance) _______________

Emergency contact: ___________________________

Phone number: _________________________

Name of your medical doctor ____________________

REASON FOR YOUR VISIT

What is your chief symptom?

____

How long? ______________________________

What has caused it? _______________________

Is it getting worse? Y / N

Is it interfering with your life/work/sleep? Y / N

What treatment have you had? ______________

____

What things make it better? ________________

____

What makes it worse? _____________________

____

Describe the pain and its' location (you may also use the drawing on back side of this page):

____

____

Do you have other symptoms: Y / N

____

Have you seen a chiropractor before? Y/N

DOCTOR'S NOTES

____

____

____

____

____

____

____

Health History

Are you taking any medications? If so, please list below as well as for what condition are they taken.

____

____

____

Have you had any of the following conditions?

__ Any heart condition	__ Alcohol/drug abuse
__ High blood pressure	__ Sexually transmitted Disease
__ HIV/AIDS	__ Asthma/Emphysema
__ Cancer/chemo	__ Fainting/Seizures
__ Headache	__ Lower back problems
__ Kidney problems	__ Hepatitis
__ Psychiatric problem	__ Epilepsy
__ Diabetes	__ Arthritis
__ Fibromyalgia	__ Gastrointestinal disorders
__ Smoker	__ Orthotics/heel lifts

Any serious medical conditions currently? ______________

____

Surgeries/treatments with approximate dates ____________

____

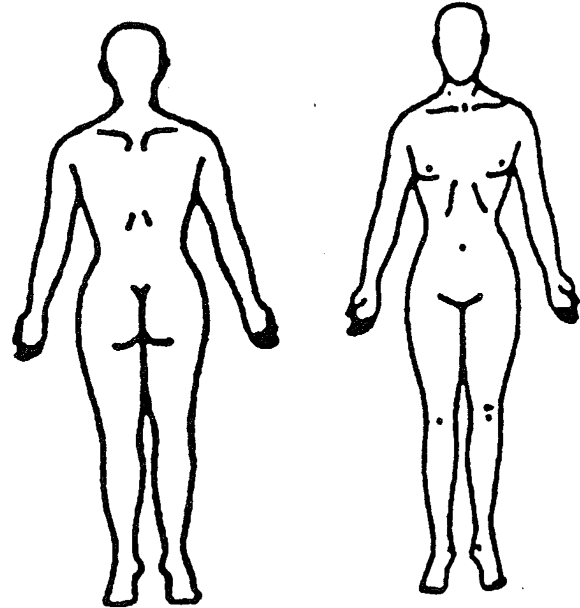
Auto or other accidents? Fractures? ________________

For women: ___ birth control pill? ___Pregnant/nursing?

Please indicate on the drawing the area(s) of pain and rate the severity on a scale of 1-10.

Circle the pain sensation you're experiencing:

Sharp Shooting Stabbing Burning Tingling Numb



- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- Our policy requires payment in full at time of service unless other arrangements have been made with our office manager. If an account is not paid within 90 days of the service and no financial arrangements have been made, you will be responsible for collection fees that may result. Communication with us is the best for you.

<u>With your signature below you are:</u>

♘ Authorizing your doctor/our staff to perform any necessary services during diagnosis and treatment. You also authorize our office to release any information required to process insurance claims.

♘ Instructing and directing your insurance company and/or attorney to make payment directly to and in the name of your doctor or this health care facility.

♘ Understanding the above information and guarantee this form was completed correctly to the best of your knowledge and understand it is your responsibility to inform this office of any changes in your health status or insurance information. You also understand that you are ultimately responsible for your account with this facility.

Signature ______________________________________ Date ____/____/_______