Dr. Ryan Klopfer, DC, MS, CSCS
Chiropractic Orthospinologist

If you need any assistance completing this paperwork, please ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

Date: _____

Patient ID:_____

_____

Last Name First Name MI "Nickname"

_____ _____

Address D.OB.

_____ _____

City State Zip/Postal Code E-mail

_____ _____ _____ _____

Home Phone Cell Phone Work phone SS # (Last 4)

_____ _____ _____

Emergency contact Primary contact # Relationship to Patient

Marital Status:

- ☐ Single ☐ Married ☐ Widowed ☐ Divorce

How did you hear about us?

- ☐ Word of mouth ☐ Facebook ☐ Practitioner Referral
- ☐ Drive by ☐ Google ☐ Class/Workshop

*if by word of mouth, whom may we thank for referring you to us? _____

Health Complaints

What is your PRIMARY complaint? _____
How long have you been experiencing this primary complaint? _____
Has this progressed over time? (worse/same/better)
What do you think caused your primary complaint?

_____

What movements or activities tend to increase your pain?

1. _____ 3. _____
2. _____ 4. _____

What movements or activities tend to decrease your pain?

1. _____ 3. _____
2. _____ 4. _____

Are there movements or activities you typically avoid?

1. _____ 3. _____
2. _____ 4. _____

What activities are you no longer doing that you would like to do?

1. _____ 3. _____
2. _____ 4. _____

Is there anything about your lifestyle that you think contributes to your pain?

_____

List any other secondary complaints you are currently experiencing: (in order of severity)

1. _____ 3. _____
2. _____ 4. _____

Stress and anxiety can cause or enhance your secondary complaints.

Do you feel that stress influences your pain? (Yes or No)

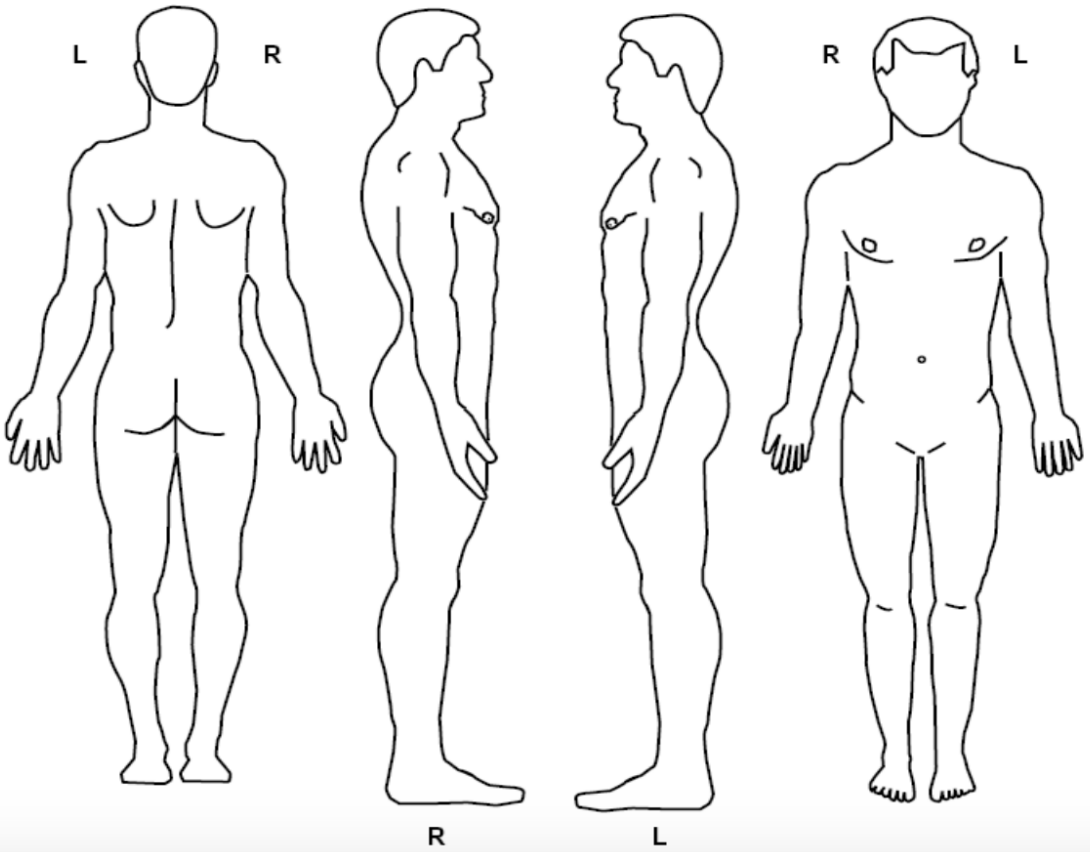
In the last 60 days, how often have you felt "stressed" or "overwhelmed"?

☐ Never ☐ Sometimes ☐ Fairly Often ☐ All the time

Do you feel that you manage your stress well? (Yes or No)

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness (N) **Tingling (T)** **Burning Pain (B)** **Stabbing Pain (S)** **Aching Pain (A)**



Lifestyle & Nutritional Habits

Occupational history:

Do you work? ☐ Yes ☐ No ☐ Disability ☐ Retired

Occupation(s):_____

Daily Habits:

On average, how many hours of television do you watch per day?

☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

On average, how many hours per day do you use a computer at work or at home?

☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

On average how many hours per day do you ride in a car or other vehicle?

☐ <1 ☐ 1-3 ☐ 3-5 ☐ >5

On average how many hours of sleep do you get per night?

☐ <6 ☐ 7 ☐ 8 ☐ >8

Do you exercise? (Yes) or (No)

If yes, how often?

☐ Daily ☐ 3-5x/wk. ☐ 2x/wk. ☐ 1x/wk.

If yes, how long are your workouts?

☐ < 0.5 hour ☐ 0.5-1hour ☐ 1-2hours ☐ >2 hours

What are your exercise activities? (mark all that apply)

☐ Walking
☐ Jogging/Running
☐ Swimming
☐ Biking
☐ Rowing
☐ Hiking
☐ Resistance Training
☐ Stretching
☐ Yoga/Pilates
☐ Intramural Sports

Do you smoke tobacco? (Yes or No) If yes, How often?_____ How much?_____

Do you use recreational drugs? (Yes or No)

How many cups of water do you drink per day?

☐ 1-3 ☐ 4-6 ☐ 7-8 ☐ >8

How many servings of alcohol do you drink per week?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many cups of coffee do you drink per week?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink per week?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

Dietary Habits:

Have you ever made changes in your eating habits due to your health? (Yes or No)

What does your diet primarily consist of? (mark all that apply)

☐ Breads & cereals
☐ Pastas & rice
☐ Lean Protein (chicken/fish)
☐ Red Meat
☐ Dairy (milk, cheese, etc.)
☐ Fruits
☐ Vegetables
☐ Healthy Fats
☐ Processed/packaged foods
☐ Cookies, crackers, pretzels
☐ Candy
☐ Soda/Energy Drinks

Family Health History

Mark the following conditions as they pertain to your family.
Include the family member: (Parents, Siblings, Children, Grandparents)

Diabetes _____
Heart conditions _____
Kidney conditions _____
Gastrointestinal issues _____
Autoimmune conditions _____
Respiratory issues _____
Musculoskeletal issues _____
Other _____

Cancer _____
Vascular Problems _____
(Including stroke)
Nerve conditions _____
(Neruopathies)
Neurological Conditions _____
(Parkinsons, MS, Dementia, etc)
Psychiatric Conditions _____

Do any family members have a condition that is similar to yours? (Yes or No)
If yes, please explain: _____

_____

Medical History:

Mark any of the following conditions as they pertain to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-immune
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Myocardial Infarction
- ☐ Measles
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Psychiatric Disorders
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Whooping Cough

Any recent illnesses or infections? (if yes, explain): _____

_____

Any known allergies or sensitivities? _____
List any broken bones or dislocations (include location and date): _____
Have you suffered any head injuries? (including concussions): _____
Were you ever knocked unconscious? (if yes, please explain): _____

Surgical History

Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws)
If yes, please explain: _____

Mark all of the following procedures as they pertain to you:

- ☐ Appendectomy
- ☐ Abdominal Surgery
- ☐ Cesarean Section
- ☐ Hernia Repair
- ☐ Thyroid Surgery
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Gall Bladder Removal
- ☐ Tonsillectomy
- ☐ Neurosurgery _____
- ☐ Spinal Surgery _____
- ☐ Cardiac Surgery _____
- ☐ Female Surgery _____
- ☐ Male Surgery _____

Medications, Vitamins, Supplements

Please list any vitamins or supplements you are currently taking:

Please list any prescription or over-the-counter medications you are currently taking and the condition for which they are for:

Injuries

List any (even minor) motor vehicle collisions that you have been involved in as either a driver or passenger. (Start with the most recent)

Type of collision	Injury & Treatment received	Date of injury

List any athletic injuries that you have experienced below. (Start with the most recent)

Type of injury	Treatment Received	Date of injury

List any other injuries that you have experienced below. (Start with the most recent)

Type of injury	Treatment Received	Date of injury

I understand and agree to the following:

It is my responsibility to complete the clinic's forms accurately and provide the most up to date information.

It is my responsibility to notify the doctor if any of the information has changed or requires updating.

Patient Name (print)	Patient Signature	Date

Parent/Guardian Name (print)	Parent/Guardian Signature	Date