New Patient Form

Klinedinst Chiropractic
103 South Main St. – Canton, IL 61520
309-647-8030

Patient Name _____ Date of Birth _____ Today's Date _____

Patient Address _____City and State _____ ZIP_____

Patient Home Phone # _____ Work # _____ Cell #_____

Social Security Number _____ Sex_____ Marital Status _____

Spouse's Name _____ Spouse Employer _____

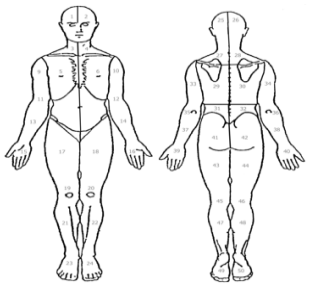
Primary Ins. Name _____ ID# _____ DOB _____

Secondary Ins Name _____ID#_____

E-mail _____ Occupation _____

Employer/School _____ Employer/School # (____)- _____-_____

How did you hear about us?_____ Emergency Name and # _____



Place a mark on "Yes" or "No" to indicate if you have had any of the

AIDS/HIV		Yes		No	Chicken Pox		Yes		No	Liver Disease		Yes		No	Rheumatoid Arthritis		Yes		No
Alcoholism		Yes		No	Diabetes		Yes		No	Measles		Yes		No	Rheumatic Fever		Yes		No
Allergy Shots		Yes		No	Emphysema		Yes		No	Migraine Headaches		Yes		No	Scarlet Fever		Yes		No
Anemia		Yes		No	Epilepsy		Yes		No	Miscarriage		Yes		No	Stroke		Yes		No
Anorexia		Yes		No	Fractures		Yes		No	Mononucleosis		Yes		No	Suicide Attempt		Yes		No
Appendicitis		Yes		No	Glaucoma		Yes		No	Multiple Sclerosis		Yes		No	Thyroid Problems		Yes		No
Arthritis		Yes		No	Goiter		Yes		No	Mumps		Yes		No	Tonsillitis		Yes		No
Asthma		Yes		No	Gonorrhea		Yes		No	Osteoporosis		Yes		No	Thuberculosis		Yes		No
Bleeding Disorders		Yes		No	Gout		Yes		No	Pacemaker		Yes		No	Tumors, Growths		Yes		No
Breast Lump		Yes		No	Heart Disease		Yes		No	Parkinson's Disease		Yes		No	Typhoid Fever		Yes		No
Bronchitis		Yes		No	Hepatitis		Yes		No	Pinched Nerve		Yes		No	Ulcers		Yes		No
Bullimi		Yes		No	Hernia		Yes		No	Pneumonia		Yes		No	Vaginal Infections		Yes		No
Cancer		Yes		No	Herniated Disk		Yes		No	Polio		Yes		No	Venereal Disease		Yes		No
Cataracts		Yes		No	Herpes		Yes		No	Prostate Problem		Yes		No	Whooping Cough		Yes		No
Chemical		Yes		No	High Cholesterol		Yes		No	Prosthesis		Yes		No	Other _____				
Dependency		Yes		No	Kidney Disease		Yes		No	Psychiatric Care		Yes		No	_____				

Exercise		Work Activity		Habits	
None		Sitting		Smoking	Packs/Day _____
Moderate		Standing		Alcohol	Drinks/Week _____
Daily		Light Labor		Coffee/Caffeine Drinks	Cups/Day _____
Heavy		Heavy Labor		High Stress Level	Reason _____

Family History of any illnesses : _____

Are you Pregnant? ☐ Yes ☐ No