Kelling Chiropractic Center
310 S. Platte Clay Way, Suite A, Kearney, MO 64060

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Social Security Number _____
Birth Date: ____/____/____ Age: ____ Gender: F / M
Marital Status: □ Married □ Separated □ Widowed □ Single

CURRENT ADDRESS

Street _____
City _____ State _____ Zip _____
Home Phone (_____) _____ Cell Phone (_____) _____

Occupation_____
Employer_____ Work Phone (_____) _____

Name of Spouse _____ Spouse's Date of Birth ____/____/____

If you are under 18 years of age, who are your legal parents or guardian?
_____ Phone (_____)_____
Student at _____□ FULL-TIME □ PART-TIME

Who should we contact in the event of an emergency?_____
Phone (_____) _____

Who Referred you ? _____
Primary Care Physician _____
Did the condition or injury result from *automobile* accident? □ YES □ NO
Did it result from a *work-related* accident or cause? □ YES □ NO
Approximately, when did your injury or condition occur? ____/____/_____
Chief Complaint _____

HABITS	**EXERCISE**
Smoking____pks/day	____ None
Alcohol_____/day	____ Moderate
Coffee_____cups/day	____Daily

Have you ever suffered from:

□ Dizziness	□ Arthritis	□ Digestive Disorders
□ Backaches	□ Headaches	□ Nervousness
□ Heart Trouble	□ Numbness	□ Sinus Trouble
□ Diabetes	□ Asthma	□ Anemia
□ Hernia	□ Neuritis	□ Cancer