KENNETH L. SCHRAMM, DC, PA
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PATIENT INFORMATION Date _____

Name: _____ Phone: (cell) _____(home) _____

Address: _____ City. State, Zip _____

Occupation/Employer: _____ Work Phone _____

Age: ____ Birth date: ____/____/____ Sex: (M) (F) Marital Status: (S) (M) (W) (D) (SEP) Email: _____

Spouse's Name: _____ Referred by: _____

In Case of Emergency Contact: _____ Phone _____

Purpose of this appointment: _____

_____

Date you were aware of this problem: _____ Have you seen any other Doctor for this condition? ( )Yes ( )No

Doctor's name: _____ Address: _____ Phone: _____

Have you been treated for any health condition in the last year? ( )Yes ( )No What? _____

List medications/drugs you are taking and why: _____

List any broken bones, dislocations, major dental work, surgeries, serious illnesses, or hospitalizations (with year in brackets):

_____

List any x-rays taken and why with date (include CAT scans, MRI, x-ray, dye studies, & dental): _____

_____

Date of last physical exam: ___/___/___ With whom? _____ Where? _____

Reported findings: _____

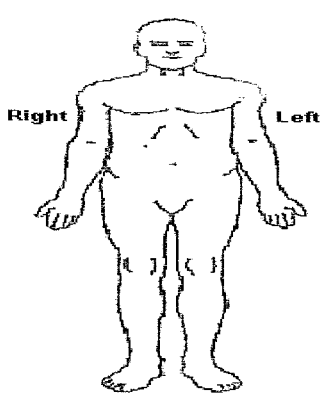
(Females) Are you pregnant? ( )Yes ( )No Difficult periods?( )Yes ( )No Birth Control?( )Yes ( )No Nursing?( )Yes ( )No

Past Chiropractic Care? ( )Yes ( )No Doctor: _____ Address: _____

When? _____ For what problem? _____

Which type of care do you prefer? (check one)

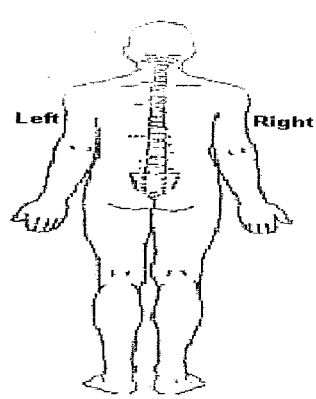
( ) Relief Care (symptomatic pain relief)
( ) Corrective Care (correction of problem/relief of symptoms)
( ) Integrated Care (to bring the body to its highest state of health)



MARK THE PROBLEM AREA

Please list your problem area with #1 the worse, and mark on the drawing.

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



Daily Habits:
( ) Smoking – Packs/Day _____
( ) Drinking-Alcohol/Day _____
( ) Coffee/Caffeinated Tea-Cups/Day _____
( ) Colas-Number per day _____
( ) Water-glasses per day _____
( ) Red meat-Times per week _____

Exercise:
( ) None
( ) Light
( ) Moderate
( ) Daily

What type of exercise: _____

Approximate number of times you urinate during the day: _____ night _____

How often do you have a bowel movement? _____ Any problems? _____

Are you a vegetarian? ( ) Yes ( ) No Do you eat in fast food restaurants? ( ) Yes ( ) No Times per week: _____

Are you dieting? ( ) Yes ( ) No How? _____

Height: _____ Weight: _____ Blood type: _____

Allergies? (Please list) _____

Please list vitamins/supplements you take: _____

Do you have sufficient energy for your normal activities? ( )Yes ( )No If not, explain: _____

Glasses or contact lenses? ( )Yes ( ) No Has your vision changed lately? ( )Yes ( )No How? _____

How is your sleep? _____ Average number of hours per night: _____ Quality? _____

Do you wear heel or foot supports? ( ) Yes ( ) No Explain: _____

Have you ever suffered from:

___Allergy shots
___Bleeding Disorders
___Circulation Problems
___Depression
___Emphysema
___Gas or Belching
___Hemorrhoids
___Hernia
___Prosthesis
___Dizziness
___Backaches
___Heart Trouble
___Diabetes
___Breathing Problems
___Tuberculosis
___Thyroid Problems
___Cancer
___Herniated Disc
___Parkinson's Disease
___Arthritis
___Headaches
___Numbness
___Asthma
___Neuritis
___Digestive Disorders
___Epilepsy
___Cataracts
___Multiple Sclerosis
___Pacemaker
___Nervousness
___Sinus Trouble
___Anemia
___Weight Loss
___Weight Gain
___Venereal/Prostate Problems
___Blood Pressure Problems
___Hepatitis
___Osteoporosis
___Rheumatic Fever

Family History:
If living, give age and health problems. If deceased, give age at death and cause of death.

Father _____ Father's Mother _____ Father's Father _____

Mother _____ Mother's Mother _____ Mother's Father _____

Brother/Sister _____

Your children _____

Payment will be made by: ( ) Cash ( ) Check ( ) Credit Card

I understand that I remain personally responsible for the total amounts due to Dr. Schramm for services rendered. Fees are payable at time of service unless other arrangements have been made in advance. I understand that Dr .Schramm does not accept Worker's Compensation patients, nor does he file Medicare or Medicaid claims, as services are non-covered. I also understand health and accident insurance policies are an arrangement between my insurance carrier and myself, and any insurance filing will be my sole responsibility. Dr. Schramm will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature _____ Date _____