KAPRAUN CHIROPRACTIC CLINIC

Michael F. Kapraun D.C.
12023 N. Seymour Rd.
P.O. Box 627
Montrose, Mi. 48457
Tel.810-639-2041 Fax 810-639-2042

Date:_____

Name: _____Address:_____

City: _____State _____Zip Code_____

Phone: _____ Alt. Number: _____Email:_____

Sex: ____Age: _____Date of birth: _____Birthplace_____

Occupation: _____Hours per week:_____

Do you like your job? _____Retired? _____When?_____

How many weeks of vacation do you take per year?_____

Past occupations_____

Marital Status:_____ # of Children_____

Religion or Personal Philosophy:_____

Family Physician:_____

Referred by:_____

What are your main health concerns? (list in order of importance)

_____

_____

_____

Patient Symptoms:

_____

_____

Mechanism of Trauma: (provide dates if applicable)

_____

_____

Quality/Character of Symptoms: *Sharp Dull Aching Shooting Numbness*

Other: _____

Onset: _____ Duration: _____

Rate intensity of Pain/Symptoms: *No pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever*

Frequency: _____ Location/Symptomatic Radiation: _____

Aggravating Factors: _____ *(activity or position or other?)*

Relieving Factors: _____ *(rest, ice, heat, or other?)*

<u>Medical History:</u>

Date of last physical exam_____ Weight_____ Height_____

Maximum weight_____ When?_____ Energy level (scale 1-10: 10 highest) ____

Blood type _____ Date of last blood test _____ Why? _____
Do you usually wake up feeling refreshed? _____ Do you have any problems falling asleep? ___ Hours of sleep/ night ___ Number of times you wake up during the night ___
Any dental work done before problem started?_____ When?_____ What?_____
Number of meals per day?_____ Snacks?_____ Vegetarian?_____ What type _____
Do you smoke now? ____ How many cigarettes per day?_____ Have you ever smoked?_____ How many cigarettes per day?_____ Have you ever used recreational drugs?_____ If so, what drugs and how long did use them?_____
Do you drink alcohol? Yes No How many drinks per week?_____
Do you drink coffee? Yes No Cups/Day_____
Do you have any known allergies? Yes No Which?_____

Current medications & how long taken:_____
_____
Current vitamins and other supplements:_____
Other treatments or health care providers tried in the past:_____
Type of water that you drink: tap spring distilled _____
Do you have any implants or transplants & when placed?(screws, pins, pacemakers, silicone etc)_____

Childhood Diseases: (Please circle)

Measles/Rubella	Diphtheria	Mononucleosis	Other:_____
German measles	Meningitis	Whooping cough	_____
Polio	Mumps	Scarlet Fever	_____
Rheumatic fever	Chickenpox	Smallpox	

VACCINATIONS: (please circle)

Pertussis	Rheumatic fever	Polio	Measles	Other:_____
Mumps	Rubella	Tetanus	Smallpox	_____

Did you have a reaction to any of these vaccinations (e.g. fever)? Yes No
If yes what type of reaction?_____

X-RAYS: Please circle
Teeth stomach gall bladder back chest colon extremities other_____
EKG? When?_____ **EEG?** When?_____
Blood or plasma transfusions ? When_____

REVIEW OF BODY SYSTEMS: Please circle **Y** for current condition and **P** if you had it in the past.

General

Cancer	Y	P	Fever/Chills	Y	P
Sensitivity to cold	Y	P	Rapid weight gain/loss	Y	P
Excessive hair loss	Y	P	Sweat easily/excessively	Y	P
Sudden tiredness/weakness	Y	P			

Time of day_____

SKIN:

Rashes	Y	P	Hives	Y	P	New moles/changes in old moles	Y	P
Psoriasis	Y	P	Acne	Y	P	Night Sweats	Y	P
Boils	Y	P	Dry skin	Y	P	How often_____		
Scabies	Y	P	Lice	Y	P			

Head:

Headache	Y	P	Injuries	Y	P	Other_____		
Dizziness	Y	P	Migraine	Y	P			

Ears:

Discharge	Y	P	Ringing	Y	P
Itching	Y	P	Earache	Y	P
Excess wax	Y	P	Hearing loss	Y	P
Infections	Y	P	Loss of balance/vertigo	Y	P

Other_____

EYES:

Glasses/contacts?_____ Since when? _____ Prescription changes? _____

Near sighted/far sighted? _____

Impaired vision	Y	P	Tearing or dryness	Y	P
Eye pain	Y	P	Glaucoma	Y	P
Double vision	Y	P	Itching	Y	P
Cataracts	Y	P	Blurring	Y	P
Redness	Y	P	Blind spot(s)	Y	P
Light Sensitivity	Y	P	Color blind	Y	P
Discharge	Y	P	Other_____		
Loss of sight	Y	P			

Nose and Sinuses:

Nose bleeds	Y	P	Stuffiness	Y	P
Hay Fever	Y	P	Allergies	Y	P
Injury	Y	P	Sinus problems	Y	P
Loss of smell	Y	P	Obstructions	Y	P

Other_____

Mouth and Throat:

Hoarseness	Y	P	Jaw clicks	Y	P
Grinding teeth or teeth problems	Y	P	Sores on lips, tongue ,mouth	Y	P
Gum problems	Y	P	Many sore throats	Y	P
Metallic taste in mouth	Y	P	Dental cavities	Y	P

Other_____

Silver fillings?_____ Gold crowns?_____ Other?_____

Any other metal appliances in the mouth?_____ What?_____

Neck:

Lump	Y	P	Goiter	Y	P
Pain	Y	P	Stiffness	Y	P
Swollen glands	Y	P	Other_____		

Respiratory:

Chronic or frequent cough	Y	P	Difficulty breathing	Y	P
Frequent colds	Y	P	Wheezing	Y	P
How many per year?_____			Asthma	Y	P
Chronic mucous in throat	Y	P	Hayfever	Y	P
Pain on breathing	Y	P	Shortness of breath	Y	P
Bronchitis	Y	P	Emphysema	Y	P
Chest pain	Y	P	Pneumonia	Y	P
Coughing blood	Y	P	Pleurisy	Y	P
Last chest x-ray_____			Last tuberculine test_____		
Other_____					

BREASTS:

Fibrous tissue	Y	P	Lumps	Y	P
Pain	Y	P	Tenderness	Y	P
Do you self examine?_____					

Cardiovascular:

Heart disease	Y	P	Chest pain/angina	Y	P
Stroke	Y	P	Phlebitis	Y	P
Ankle swelling	Y	P	High blood pressure	Y	P
Palpitations/irregular heart beat	Y	P	Murmurs	Y	P
Rheumatic fever	Y	P	Last ECG test	Y	P
Other_____					

Gastrointestinal:

Difficulty swallowing	Y	P	Diarrhea	Y	P
Food allergies	Y	P	Abdominal pain	Y	P
Colitis	Y	P	Appendicitis	Y	P
Spitting up blood	Y	P	Heartburn	Y	P
Rectal bleeding/bloody stool	Y	P	Change in thirst	Y	P
Hemorrhoids	Y	P	Change in appetite	Y	P
Black stool	Y	P	Change in bowel movement	Y	P
Jaundice	Y	P	Constipation	Y	P
Nausea/vomiting	Y	P	Hernias	Y	P
Indigestion/bloating	Y	P	Hepatitis	Y	P
Belching/gas	Y	P	Other_____		

Symptoms relieved by eating or worse?_____

Number of bowel movements per day?_____ Regular? Yes No

Food desires/cravings_____

Foods that disagree_____

Food aversions_____

Urinary:

Pain on urination	Y	P	Kidney stones	Y	P
Increased frequency	Y	P	Blood/sugar/pus in urine	Y	P
Inability to urinate	Y	P	Frequent infections	Y	P
Abnormal thirst	Y	P	Decrease in flow	Y	P
Swelling of hands/feet/ankles	Y	P	Color of urine: Pale	Yellow	Dark Frothy
Bladder/kidney disease or infections	Y	P	Other_____		

Musculoskeletal:

Joint pain or stiffness	Y	P	Muscle spasm/cramps	Y	P
Arthritis/rheumatism	Y	P	Weakness	Y	P
Broken bones	Y	P	Back pain	Y	P
Numbness/tingling	Y	P	Shoulder pain	Y	P

Aggravating or relieving factors:

_____

Peripheral Vascular:

Cold hands/feet	Y	P	Varicose veins	Y	P
Deep leg pain	Y	P	Thrombophlebitis	Y	P

Other_____

Reproductive:

Sexual difficulties	Y	P	Chlamydia	Y	P
Herpes	Y	P	Syphilis	Y	P
Gonorrhea	Y	P	Genital infection	Y	P
Non-specific venereal disease	Y	P	Warts on genitals	Y	P
Are you sexually active now?	Yes	No	HIV+	Yes	No

Sexual preference: Heterosexual_____ Bisexual_____ Homosexual_____

Pain during intercourse Yes No Increased/decreased sex drive YesNo

Males:

Prostate disease	Y	P	Premature ejaculation	Y	P
Impotence	Y	P	Other_____		

Females:

Menopause: Yes No If yes what age_____ Symptoms:_____

Type of birth control_____ Since when?_____

Menses: Regular cycle? Yes No Length of cycle: _____days Duration of flow: _____days

Heavy? Medium? Light? Clots? Pain or cramps? Yes No Before/after flow starts

First day of last menses_____ Age at first menses_____

No. of pregnancies?_____ No. of miscarriages?_____ No. of abortions_____

Complications with pregnancies? Yes No Date of last PAP?_____

Vaginal discharge	Y	P	Frequent yeast/other infections	Y	P

Other_____

PreMenstrual Syndrome symptoms:

Depression	Y	P	Weight gain	Y	P
Bloating	Y	P	Breast tenderness	Y	P
Increased appetite	Y	P	Other_____		

Neurolgical:

Fainting	Y	P	Loss of memory/poor memory	Y	P
Areas of numbness/tingling/ paralysis	Y	P	Seizures/Convulsions	Y	P
Involuntary movements	Y	P	Loss of balance	Y	P
Muscle weakness	Y	P	Speech problems	Y	P
Loss of coordination	Y	P	Hallucinations/mental confusion	Y	P
Concussion/head injury	Y	P	Poor concentration	Y	P

Other_____

Endocrine:

Thyroid problems	Y	P	Hormone therapy	Y	P
Diabetes	Y	P	Hypoglycemia	Y	P

Other_____

Blood/lymphatics:

Anemia	Y	P	Lymph node swelling	Y	P
Easy bleeding/bruising	Y	P	Blood transfusions	Y	P

Other_____

Psycho/Social:

Depression	Y	P	Tension	Y	P
Attempted suicide	Y	P	Easily angered/easy to cry	Y	P
Mood swings	Y	P	Phobias	Y	P
Anxiety/Nervousness	Y	P	Sleep problems	Y	P

Have you ever had psychiatric-psychological counseling?_____

How content are you with your life?(1-10; 10 very content)_____

What would you like to change in your life?_____

Do you express your emotions easily? _____ What are the major stresses in your life?_____

Alcohol or drug abuse? Yes No Other_____

Habits and lifestyle:

Do you participate in sports or have any hobbies or activities that give you relaxation at least 3 hrs weekly?

Yes No If yes what type of activities? How many hours?

1._____

2._____

3._____

4._____

Preferences:

	Most liked	Least liked
Color	_____	_____
Taste	_____	_____
Climate	_____	_____
Time of day	_____	_____
Temperature	_____	_____

Family History: Please check which diseases apply to any blood relative.

	Mother	Father	Sister	Brother	Grandma	Grandpa	Other/who?
Cancer-What type?							
Hereditary disease-What?							
Skin allergies/Hives							
Eczema/Psoriasis							
Arthritis/Gout							
Kidney disease							
Respiratory allergies							
Asthma							
Lung disease/TB							
Liver disease, Cirrhosis							
Food allergies/Digestive problems							
Hypoglycemia/Diabetes							
Thyroid problems/ Obesity							
High blood pressure							
Arteriosclerosis/Vascular disease/Stroke							
Heart attack/Heart disease							
Nervous breakdown/ Epilepsy							
Syphilis							
Gonorrhea							
Miscarriages							

Please list in order of appearance from your birth, all hospitalizations, surgeries, diseases, major accidents, traumas, and scars(emotional and physical

Age _____ _____
Age _____ _____
Age _____ _____
Age _____ _____

Is there anything else that you feel I should know about you?

_____
_____
_____

Notice

Please present any insurance information or inform us of any changes in your address, telephone number, insurance, etc. at the time of service.

Supplements must be paid for at the time of purchase.

Patients are responsible for all fees not covered by Insurance.

Thank you for your cooperation.

Date:_____

Signature:_____