CRESCO CHIROPRACTIC CLINIC P.C.
John P. Gehling, D.C. Joshua T. Lichty D.C. Sarah A. Gehling C.A.
407 7th St. S.W., Cresco, IA 52136 Website: www.crescochiropracticclinic.com
Phone: (563) 547-3553 Fax: (563) 547-3552

Confidential Patient Information

Full Name _____ Social Security # _____

Date of Birth_____ Age _____ Gender: M or F Marital Status: M S W D #Children_____

Address _____
Address City State Zip Code

Home Phone #_____ Cell Phone _____ Email_____

_____
Your Occupation Company Name City Work Phone

_____
Spouse or Guardian's Name Occupation Company Name City

Emergency Contact_____
Name Relationship Phone Number

How did you hear about us? ☐ Cresco Shopper ☐ Times Plain Dealer ☐ TPD Online ☐ Word of Mouth

☐ Yellow Book ☐ Iowa Telecom Phonebook Other please list: _____

Have you ever been to a chiropractor before? ☐ Y or ☐ N If yes, please list:_____

Who is your current medical doctor(s)?_____

Please list all surgeries and hospital or ER visits that you have had and the dates:_____
_____
_____

Do you have health insurance? ☐ Yes ☐ No Company _____
(If yes, please present your card(s) to the receptionist for processing)

Is this insurance in your name? ☐ Yes ☐ No if no, list: ___
(name of insured)

Insured's date of Birth _____ Relationship to you ☐ Spouse ☐ Parent Other_____

What is your main reason for coming to our office today?_____
_____

When did it start? _____What caused it? _____

What makes it better? _____What makes it worse? _____

What percentage of each day does it currently bother you? (Circle one) 0% 25% 50% 75% 100%

Please rate your pain on a scale of 1-10: **0 is no pain at all, 10 is the severe pain** or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate the range of your pain.

0 1 2 3 4 5 6 7 8 9 10

What are you unable to do because of this problem?_____

How did this problem/pain start? _____ ☐Gradual ☐Sudden ☐Progressive

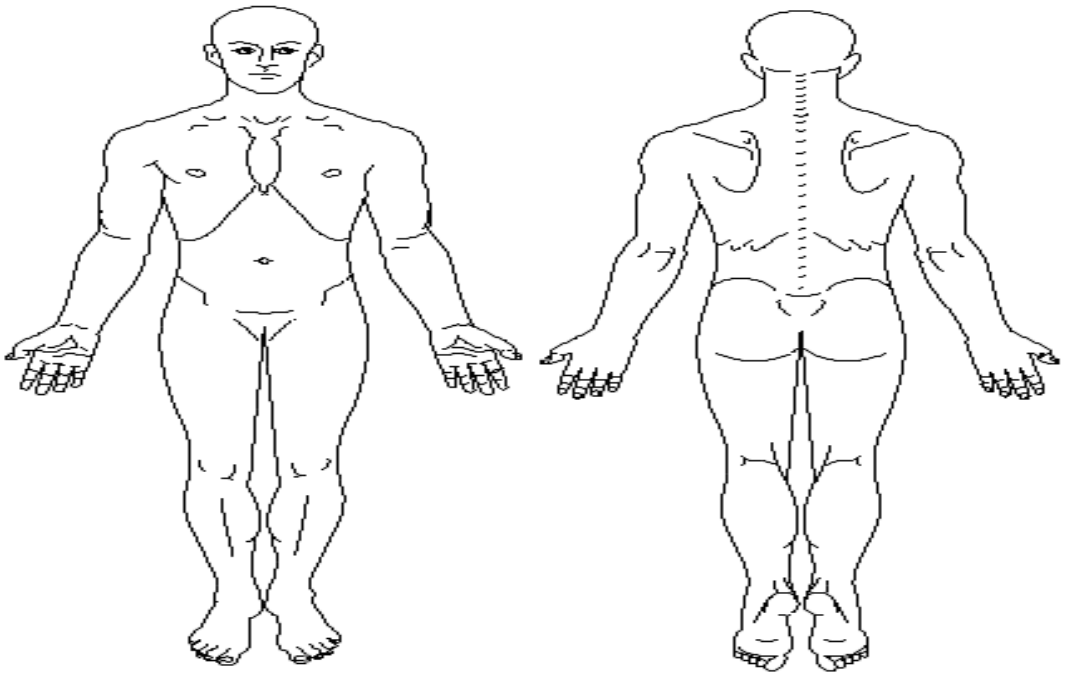
Have you ever experience this problem before? ☐Y or ☐N If so, when?_____

List any other problems you have and rate your pain for each.

a_____	0 1 2 3 4 5 6 7 8 9 10	25% 50% 75% 100%
b_____	0 1 2 3 4 5 6 7 8 9 10	25% 50% 75% 100%
c_____	0 1 2 3 4 5 6 7 8 9 10	25% 50% 75% 100%
d_____	0 1 2 3 4 5 6 7 8 9 10	25% 50% 75% 100%

Please Indicate All Areas Where You Experience Pain

X = Sharp Pain # = Dull Ache **^** = Numbness
******* = Pins and Needles **+** = Burning Pain



Personal Health History – The following lists a variety of conditions that patients may experience. Please read through the list and mark a "C" for current conditions, "H" for history, "F" for family history or "?" if unsure.

___heart attack
___artificial valves
___pacemaker/ implant
___heart murmur
___heart disease
___chest pain
___varicose veins
___other
___high/low blood pressure
___dizziness/general fatigue
___stroke
___asthma/emphysema
___shortness of breath
___loss of balance
___blurred or double vision
___detached retina
___diabetes
___diarrhea/ constipation
___gall bladder trouble
___liver trouble
___digestive problems
___belching/bloating
___heartburn/acid reflux
___ulcers
___appendectomy
___colon trouble
___nausea/ vomiting
___bloody stools
___anemia
___gout
___knee/hip replacement
___osteoporosis
___rheumatoid arthritis
___osteoarthritis
___neuritis (nerve pain)
___soreness of joints
___sprained ankle R or L
___swollen or painful joints
___jaw pain or TMJ
___shoulder pain
___mid-back pain
___hip pain
___foot trouble
___neck pain
___knee pain
___lower back pain

___broken bones
___artificial joints/implants
___orthopedic surgery
List: _____
___compression fracture
___ears ringing
___loss of memory
___muscle cramping
___muscle spasm
List:_____
___fainting spells
___headaches
___loss of hearing
___epilepsy/ seizures
___light sensitivity
___pain with cough/sneeze
___spinal disorder
List: _____
___glaucoma
___AIDS/HIV
___cancer
___tuberculosis
___venereal disease
List: _____
___hepatitis
___frequent colds/flues
___multiple sclerosis
___malaria
___shingles/ chicken pox
___measles
___mumps
___pneumonia
___polio
___lupus
___fibromyalgia
___whooping Cough
___difficulty with urination
___prostate trouble
___kidney stones
___impotence
___frequent urination
___psychiatric problems
___alcohol/drug problems
___nervousness
___tension

___eating disorder
___trouble concentrating
___learning disability
___mood changes
___menstrual cramping
___menopausal problems
___breast lumps/soreness
___miscarriage
___sinus problems
___cold sores
___skin problems
List: _____
___excessive sweating
___tremors
___ear infections
___under stress
___numbness and tingling
___trouble sleeping
___thyroid disorder
___hormone disorder
___immune disorder
List: _____
___allergies
List: _____
___other accidents/falls
List: _____
___auto accidents
List: _____

General Activities
___sleep on waterbed
___sleep on stomach
___sewing
___exercise (_____x/wk)
___swim
___read in bed
___needlepoint/knitting
___lift weights
___jog/run (____ hrs/wk)
___use cardio-equipment (_____ hrs/wk)
___sleep in recliner/couch
___use two or more pillows
___computer/TV/video game use (_____ hrs per day)

Who else have you seen for this condition:_____

Are you taking any of the following medications? ☐ Pain Killers ☐ Muscle Relaxants ☐ Blood pressure ☐ Insulin ☐ Cholesterol ☐ Blood Thinners Other_____

Do you take supplements or vitamins? ☐ Y or ☐ N if yes, what kind? _____

Do you exercise? ☐ Y or ☐ N if yes, how many hours per week? _____

Do you use tobacco? ☐ Y or ☐ N if yes, how much and for how long? _____

Do you use alcohol? ☐ Y or ☐ N if yes, how many drinks per week? _____

Are you wearing? ☐ heel lifts ☐ arch supports

For women: Are you taking birth control? ☐ Y or N ☐

Are you, or could you be pregnant? ☐ Y or N ☐

How would you like us to handle your problem?

☐ Patch (help the symptoms only)
☐ Fix (correct the cause of the problem for better health in the future)

Patient's Signature _____ Date_____
(Signature of parent if the patient is a minor)

We invite you to discuss with us any questions regarding our services! The best services are based on a friendly, mutual understanding between provider and patient.