THRIVE Milpitas
a Kauffman Chiropractic, Inc.

Developing Strong Pain Free People

● Chiropractic ● Massage ● Acupuncture ● Physical Rehabilitation ● Fitness & Natural Weight-Loss ● Yoga

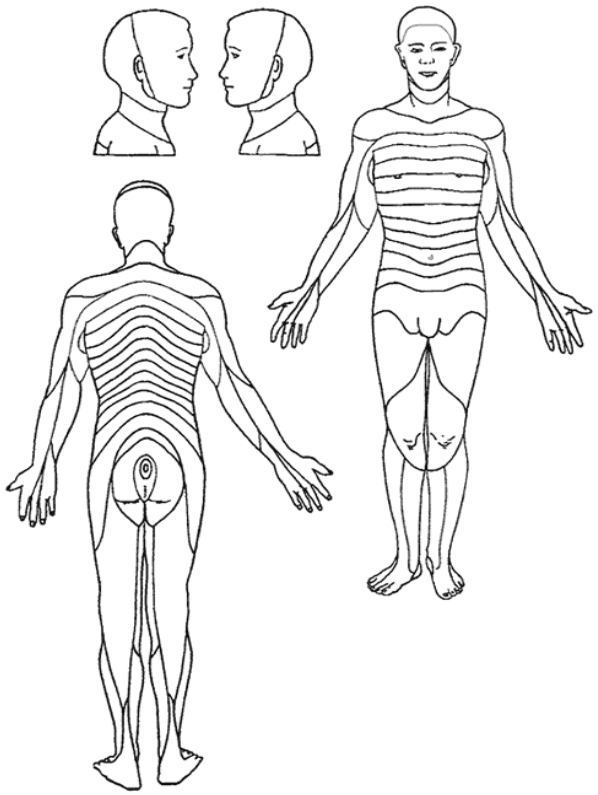
Patient Information		
First Name:	**Middle:**	**Last:**
Gender: · **Female** · **Male**		
Street:		**City:**
Prov/State:	**Country:**	**Postal Code:**
E-mail:		**Date of Birth:**
Home Telephone:		**Cell Telephone:**
Work Telephone:	**Ext:**	**SSN:**
How did you hear about us? · **Yelp!** · **Google** · **Yahoo!** · **Our Website** · **Gym Member** · **Patient / Doctor Referral / Other:**_____		

Emergency contact information		
Emergency Telephone:		
Emergency Contact Name:		
Gender: ·**Female** ·**Male**		**Relationship:**

Employer information	
Employer Name:	
Employer Telephone:	**Extension:**
Street:	**City:**
Province/State:	**Postal code:**
Country:	**Work Email:**
Occupation:	

Insurance information	
Member ID:	**Carrier Phone:**
Group Number:	**Case/Claim number:**
Primary Physician:	**Telephone:**
Other Physician	**Telephone:**
Who is responsible for the account? ·**Patient** ·**Other**	**Name of the primary insurance carrier:**
Is patient covered by additional insurance? ·**No** ·**Yes**	**Name of the insurance company:**

Current Health Concerns (Please select only one severity)				
1.	·**Irritability**	·Mild	·Moderate	·Severe
2.	·**Arm Pain**	·Mild	·Moderate	·Severe
3.	·**Neck Pain**	·Mild	·Moderate	·Severe
4.	·**Back Pain**	·Mild	·Moderate	·Severe
5.	·**Leg Pain**	·Mild	·Moderate	·Severe
6.	·**Headache**	·Mild	·Moderate	·Severe
7.	·**Bad Posture**	·Mild	·Moderate	·Severe
8.	·**Meningitis**	·Mild	·Moderate	·Severe
9.	·**Migraines**	·Mild	·Moderate	·Severe
10.	·**Sciatic Nerve**	·Mild	·Moderate	·Severe
11.	·**Joint Pains**	·Mild	·Moderate	·Severe
12.	·**Numbness**	·Mild	·Moderate	·Severe
13.	·**Carpel tunnel**	·Mild	·Moderate	·Severe
14.	·Dizziness / Vertigo	·Mild	·Moderate	·Severe
15.	·Stress	·Mild	·Moderate	·Severe
16.	·Weight Loss Gain	·Mild	·Moderate	·Severe
17.	·Fatigue	·Mild	·Moderate	·Severe
18.	·Tinnitus	·Mild	·Moderate	·Severe
19.	·Depression	·Mild	·Moderate	·Severe
20.	OTHERS:			



Please indicate (on drawing above) to indicate your current symptoms.

What are your current health concerns?

What have you tried to get rid of these problems?

Has this problem interfered with any activities? (Work, Family, Sleep or Exercise)

Work activity	Sleeping position	Hours of sleep
· None	· Back	· 1-3
· Sedentary	· Side	· 4-6
· Moderate	· Stomach	· 7-9
· Heavy	· Varies	· More than 10

Trauma History	· Surgeries	Exercise
· Falls	· Auto accidents	· None
· Head injuries	· Other 1	· Moderate
· Broken bones	· Other 2	· Heavy
· Dislocation	· Other 3	· 1-2 · 3-4 · 5-7 Days a Week
		· <30 · 30-60 · >60 min a day
Current Medication	· Blood pressure	
· Anti- inflammatory	· Other Medications:	
· Pain killers		
· Muscle relaxant		

Date of last examination			
·Chiropractic	· Less than 6 months	· 6 months to 1 year	· 1 to 2 years
·Physical examination :	· Less than 6 months	· 6 months to 1 year	· 1 to 2 years
·X-Ray examination :	· Less than 6 months	· 6 months to 1 year	· 1 to 2 years
·Blood tests :	· Less than 6 months	· 6 months to 1 year	· 1 to 2 years
·Urine tests :	· Less than 6 months	· 6 months to 1 year	· 1 to 2 years

Patient Name_____ **Date**_____

Reviewed by Doctor_____**(Office Only)**_____ **Date**_____