King Chiropractic, P.C.

SPORTS, SPINAL AND ORTHOPAEDIC DISORDERS

Dr. L. Neil King
FOUNDER – 1984

Dr. Kelly C. Groves
CHIROPRACTIC DIRECTOR

Linda Reed
OFFICE MANAGER
CERTIFIED CHIROPRACTIC ASSISTANT

Lisa Crawford
PATIENT ADVOCATE
CERTIFIED CHIROPRACTIC ASSISTANT

Name:_____ ☐F ☐M Age:_____ Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

Occupation:_____ Work Phone:_____

Are you currently seeing a chiropractor?_____

Check off any of the following symptoms you have experienced in the past 6 months:

- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Pain Between Shoulder Blades
- ☐ Difficulty sleeping
- ☐ Tension/ Migraine headaches
- ☐ Tired, Fatigue
- ☐ Tension across top of shoulders
- ☐ Numbing/Tingling in arms or hands
- ☐ Numbing/Tingling in Legs or Feet
- ☐ Digestive Problems
- ☐ Ringing in Ears
- ☐ Nervousness
- ☐ Allergies
- ☐ Dizziness
- ☐ Weight Gain

Which of the above is the worst?

_____

How long have you had it?

_____

When it is at its worst, how does it feel?

_____

_____

Does this cause you to:

- ☐ Be Moody or Irritable
- ☐ Loose Sleep
- ☐ Limit your Daily Activities

Does this affect your work as in:

- ☐ Decision Making
- ☐ Poor Attitude
- ☐ Decreased Productivity
- ☐ Exhausted at end of day
- ☐ Unable to work long hours

Does this affect your home life as in:

- ☐ Loose patience with spouse or children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or participate in hobbies or other desired activities

Have you seen a doctor for this in the past?

☐Yes ☐No

Would you like to get rid of this problem?

☐Yes ☐No

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