New Client Registration

Patient Demographics

Date: _____ File Number: _____

Full Name: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Address: _____ Injury/Illness Date: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Age: _____

Employer Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Who referred you to our office: _____ Mobile Phone: _____

May we contact you by e-mail: _____

Student: ☐ Full Time ☐ Part Time School: _____

Spouse

Name: _____ Employer: _____ Date Of Birth: _____

Employer Address: _____ Employer Phone: _____

City: _____ State: _____ Zip: _____ Spouse Phone: _____

Health Information

Reason For Your Visit: _____

Other Doctors' Seen For This Condition: _____ Response: _____

Symptoms Started: _____ Is It Getting Worse: ☐ yes ☐ no Pregnant: ☐ yes ☐ no

Have You Had This In The Past: ☐ yes ☐ no Explain: _____

Is It Painful To: ☐ Sit ☐ Walk ☐ Bend ☐ Stand ☐ Lie Down ☐ Lift Objects

Does It Interfere With: ☐ Work ☐ Exercise ☐ Sleep ☐ Daily Routine ☐ Recreation

Do You Take: ☐ Muscle Relaxers ☐ Pain Killers ☐ OTC ☐ Other _____

Have You Been Treated By A Chiropractor Before: ☐ yes ☐ no Explain: _____

List Medical Conditions and Surgeries: _____

Patient Agreement

Assignment & Release

To Doctor: Kyle McKamey, DC PLLC

AFTER READING LINE 1-4, PLEASE INITIAL EACH ITEM AND SIGN THIS AUTHORIZATION AT THE BOTTOM

_____ 1. I hereby authorize Kyle McKamey, DC PLLC to **release any information** deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

_____ 2. I hereby authorize the **direct payment to Kyle McKamey, DC PLLC** of any sum I now or hereafter owe by my attorney out of any proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or this practice based in whole or in part upon the charges made for rendered services.

_____ 3. I hereby authorize the **use of this signature** on all my insurance submissions made on my behalf by Kyle McKamey, DC PLLC.

_____**4.** I hereby authorize the practitioners at Kyle McKamey, DC PLLC/Down to Earth Chiropractic & Rehabilitation to perform any examination and administer care as deemed necessary and within their scope of practice.

Signature Of Insured: _____ Date Signed: _____

(269)462-9464, (269)462-9692 Fax, www.drkylemckamey.com, drkyle@drkylemckamey.com

Children/ages:

Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

Do you currently or have you ever done any of the following:

Smoke?	Y	N	NOW/PREVIOUSLY _____PACKS PER DAY
Drink?	Y	N	NOW/PREVIOUSLY _____DRINKS PER DAY
Diet (do you eat healthy foods?)	Y	N	
Have you been in accidents?	Y	N	CAR SPORTS WORK
Spinal Surgery?	Y	N	DATE _____ REASON_____
Exercise regularly?	Y	N	
Have sleeping problems?	Y	N	HOURS OF SLEEP PER NIGHT _____
			WAKE FREQUENTLY? Y N
			DIFFICULTLY FALLING ASLEEP? Y N
			Sleeping posture: SIDE BACK STOMACH
Have occupational stress?	Y	N	
Have physical stress?	Y	N	
Have mental stress?	Y	N	

Do you have issues with sexual function that you would like to discuss? Yes/No
Yes, please explain_____

Favorite Hobbies/Activities:

List both past and current:

_____
_____

Have you ever suffered any injuries while engaging in any of these activities? Yes/No
Which one(s)? _____

Family Heath History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Other symptoms/illnesses you have had in past or are currently experiencing:

❒ Neck Pain	❒ Pins & Needles in Legs	❒ Stomach Upset	❒ Chest Pains
❒ Headaches	❒ Pins & Needles in Arms	❒ Constipation	❒ High Blood Pressure
❒ Migraines	❒ Numbness in Fingers	❒ Loss of Balance	❒ Low Blood Pressure
❒ Light-Sensitive Eyes	❒ Numbness in Toes	❒ Buzzing in Ear	❒ Fainting
❒ Back Pain	❒ Shortness of Breath	❒ Hemorrhoids	❒ Cold Sweats
❒ Nervousness	❒ Fatigue/tired all the time	❒ Diabetes	❒ Loss of Memory
❒ Tension	❒ Depression	❒ Heart Conditions	❒ Excessive Sweating
❒ Irritability	❒ Fever	❒ Skin Conditions	❒ Loss of Smell
❒ Dizziness	❒ Diarrhea	❒ Hearing Loss	❒ Loss of Taste
❒ Face Flushed	❒ Feet cold	❒ Eye Problems	
❒ Neck Stiff/Painful	❒ Hands Cold	❒ Teeth Problems	

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

***As result of my chiropractic care, I would like to (*check all that apply):**

❒ Feel better quickly ❒ Have a healthier body by keeping my nervous system healthy
❒ Have a healthier spine ❒ Live a healthier lifestyle

I am interested in the following type of Chiropractic care:

❒ Pain Relief Only ❒ Corrective/Rehabilitative Care ❒ Preventative Care

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