JASON M. KEHR, D.C.

KEHR CHIROPRACTIC
2008 3RD ST., SUITE B
LA GRANDE, OR 97850
541-963-9632

CONFIDENTIAL PATIENT INFORMATION

NAME _____ SS# _____ DATE _____
MAILING
ADDRESS _____
CITY/STATE/ZIP _____
PHONE(H) _____ (W) _____ (C) _____
AGE _____ BIRTH DATE _____ MARITAL STATUS: **S M W D**
OCCUPATION _____ EMPLOYER _____
EMPLOYER'S ADDRESS _____ SPOUSE'S BIRTH DATE _____
PARENT (IF MINOR) _____ PHONE _____

RECOMMENDED BY: _____

WOULD YOU LIKE TO RECEIVE YOUR STATEMENTS BY E-MAIL **YES** **NO**
E-MAIL ADDRESS _____
FAMILY PHYSICIAN _____ LAST SEEN _____
HAVE YOU HAD CHIROPRACTIC CARE BEFORE **YES** **NO**
BY WHOM (name & address) _____

****

PRESENT SYMPTOMS/COMPLIANTS
IS THIS AUTO OR WORK RELATED **YES** **NO** DATE OF INJURY _____
DESCRIBE ACCIDENT _____
ARE YOU PREGNANT **YES** **NO** EMERGENCY CONTACT (NAME & PHONE) _____

****

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWINGS SYMPTOMS:

___ VISUAL DISTURBANCE	___ RAPID HEARTBEAT	___ DIABETES
___ DIFFICULTY SWALLOWING	___ DIFFICULTY SPEAKING	___ HEADACHES
___ SHORTNESS OF BREATH	___ MUSCLE WEAKNESS	___ DIZZINESS
___ LOSS OF FEELING/NUMBNESS	___ HIGH BLOOD PRESSURE	___ TINNITUS (EAR NOISE)

********** **PAYMENT IS EXPECTED AT THE TIME OF SERVICE** **********
PERSON RESPONSIBLE FOR PAYMENT: _____
INSURANCE COMPANY _____ INSURED _____
ID# _____ GROUP# _____ INSURED DOB _____
OTHER INSURANCE _____ INSURED _____

******* *DO YOU CARRY **AFLAC**, **COMBINED**, OR OTHER **ACCIDENT** POLICY **Y** **N*** *******

HEALTH AND ACCIDENT INSURANCE ARE AN ARRANGEMENT BETWEEN CARRIER AND PATIENT. THIS OFFICE WILL ASSIST IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY. IT SHOULD BE UNDERSTOOD THAT ALL SERVICES FURNISHED ARE CHARGED TO THE PERSON WHO IS RESPONSIBLE FOR PAYMENT.

PATIENT SIGNITURE _____

PARENT / GUARDIAN SIGNATURE _____

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CONFIDENTIAL PATIENT INFORMATION

NAME: _____

MEDICATIONS: (NAME & REASONING) OVER THE COUNTER

_____ _____
_____ _____
_____ _____

FRACTURES: (DATE & WHAT FRACTURED)

_____
_____
_____

SURGERIES: (DATE & TYPE)

_____
_____
_____

X-RAYS / MRIS: (DATE, WHERE, VIEW)

_____
_____
_____

ACCIDENTS: (DATE & AUTO, ON THE JOB, OTHER)

_____
_____
_____

SERIOUS ILLNESS / HOSPITALIZATION: (DATE & EXPLAIN)

_____
_____
_____

IF NONE OF THESE APPLY TO YOU, PLEASE MARK WITH "N/A" THEN SIGN AND DATE. THANK YOU!

SIGNATURE: _____ DATE: _____

Medical Update

I have read my medical history dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient's Signature	Reviewed by
_____	_____	None	_____	_____
_____	_____	None	_____	_____
_____	_____	None	_____	_____
_____	_____	None	_____	_____