BODY IN BALANCE



# DR. AMY KEMPFER

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# NEW PATIENT INTAKE FORM

PATIENT INFOR)	MATION			
LAST NAME	FIRST NAME	MI	PREFERRED NAME_	
D.O.B/ SSN				
CITY	STATE		ZIP CODE	
EMAIL	PHONE		ALT. PHONE	
IS IT OK TO LEAVE DETAILED MESSA WOULD YOU LIKE TO BE ADDED TO WHOM MAY WE THANK FOR REFER	OUR EMAIL LIST FOR NEWSLET	TERS, SCHEDULE	CHANGES, UPDATES, ETC.?	
EMPLOYME	nt informati	ION		
EMERGENCY	CONTACT INF	ORMATI	0N	
WHOM SHOULD WE CONTAC	T?		RELATION	
PHONE NUMBER		CELL NUMB	ER	
PATIENT PAS	T HEALTH HISTO	RY		
	MAJOR TRAUMA/INJURY? (BRO		ACCIDENTS, CONCUSSIONS)	□ YES □
	AL PROCEDURES, OUTPATIENT		D/OR HOSPITALIZATIONS?	□ YES □
HAVE YOU HAD A PREVIOUS	OR CURRENT DIAGNOSIS OF C	ANCER?   YE	S □ NO IF YES, WHEN?	

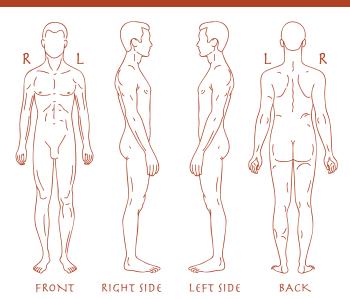
EXERCISE   DAILY   DESTIMES/WEEK   4-65 TIMES/WEEK   WHAT TYPES?  ALCOHOL USE   DAILY   WEEKLY   MONTHLY   HOW MUCH?  DO YOU USE RECCREATIONAL DRUGS?   YES   NO  DO YOU CURRENTLY OR PREVIOUSLY USED TOBACCO PRODUCTS?   YES   NO  IF SO, WHAT TYPE(S)?   HOW LONG?    FOUND OFTEN?   HOW LONG?	NUI	IBEF	OF	СН		STORY  N & AGES					□ N/A I DON'T HAVE CHILDREN
DO YOU USE RECREATIONAL DRUGS?	EXE	RCIS	E		□ DA	ILY 🗖 1-3 T	IMES/WEEK	□ 4-6 TIM	ES/WEEK	WHAT TYPES?	
DO YOU CURRENTLY OR PREVIOUSLY USED TOBACCO PRODUCTS?				_					LY	HOW MUCH?	
IF SO, WHAT TYPE(S)?  HOW OFTEN?  DISE THE FOLLOWING INDICATORS: M= MOTHER F= FATHER SI= SISTER B= BROTHER D= DAUGHTER SO= SON  IF SI B D SO  HEART CONDITIONS  ONE-MANIORISMONE REHIRBITS GOLD CROWN'S DISEASE/LICEBATIVE COLUITS OTHER AUTOMALINE OR AUTOMALINE PROPRIED CONSTRUCT  IF SI B D SO  CIRCULATORY CONDITIONS  OSTEROPHOROUS CONTROLORS  IF SI B D SO  OSTEROPHOROUS CONTROLORS  IF SI B D SO  OSTEROPHOROUS OR OTHER BONE DENSITY DISEASE/CONDITION  CURRENT MEDICAL INFORMATION  IN THE PAST 3 MONTHS HAVE YOU HAD OR ARE YOU  EXPERIENCING:  OFFICIAL SI SUPERILLS / SWEATS  CHANGE (MORE THAN 10 LBS)  DIFFICULTY SLEEPING  CURRENT MEDICATION LIST  PLEASE INDICATE DOSAGE (IF KNOWN) FREQUENCY AND ANY OVER-THE COUNTER MEDICATIONS, VITAMINS/SUPPLEME  DO YOU HAVE ANY MEDICATION ALLERGIES?  DO YOU TOLERATE MANUAL ADJUSTING (HANDS-ON)?  PYES D NO IF NO, PLEASE EXPLAIN.									00 = V	FC = NO	
USE THE FOLLOWING INDICATORS: M= MOTHER F= FATHER SI= SISTER B= BROTHER D= DAUGHTER SO= SON  IF SI B D SO HEART CONDITIONS DIERRIT DISPASSE INFERTENSION, HEART MURMURS, GENETIC DEFECTS)  INFLAMMATORY CONDITIONS DIRECTION DISPASSE INFERTENSION HEART MURMURS, GENETIC DEFECTS)  INFLAMMATORY CONDITIONS DIRECTION DISPASSE INFERTENSION CONTINUES.  INFLAMMATORY CONDITIONS STROKE, HEARDSHILLA, OR OTHER) STROKE, HEARDSHILLA, OR OTHER) CURRENT MEDICATION  IN THE PAST 3 MONTHS HAVE YOU HAD OR ARE YOU EXPERIENCING: DISPASSE OF THAN 10 LBS) DISPICULTY SLEEPING DUE TO PAIN  LAST PHYSICAL EXAM PRIMARY CARE PHYSICIAN CHINE CURRENT MEDICATION LIST PLEASE INDICATE DOSAGE (IF KNOWN) FREQUENCY AND ANY OVER-THE-COUNTER MEDICATIONS, VITAMINS/SUPPLEME  DO YOU HAVE ANY MEDICATION ALLERGIES? DO YOU TOLERATE MANUAL ADJUSTING (HANDS-ON)? DO YOU TOLERATE MANUAL ADJUSTING (HANDS-ON)?  PYES NO IF NO, PLEASE EXPLAIN											V LONG?
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USE THE FOLLOWING INDICATORS: M= MOTHER F= FATHER SI= SISTER B= BROTHER D= DAUGHTER SO= SON  1  F SI B D SO HEART CONDITIONS											
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IN F SI B D SO INFLAMMATORY CONDITIONS IRRELMATORY CONDITIONS IN THE PAST 3 MONTHS HAVE YOU HAD OR ARE YOU	USE	THE	FOI	LO\	NING	INDICATORS: M	= MOTHER <b>F</b>	= FATHER SI=	SISTER B=	BROTHER D= DA	AUGHTER SO= SON
IN F SI B D SO INFLAMMATORY CONDITIONS IRHEUMATIOP/SOBRAIC ARTHRITS. GOUT. CROHN'S DISEASE/ULCERATIVE COLITIS. OTHER AUTOIMMUNE OR AUTOIMUNE OR AUTOIMMUNE OR AUTOIMENT OR AUTOIMMUNE OR AUTOIMMUNE OR AUTOIMUNE OR AUTOIMMUNE OR	4 F	SI	В	D	S0						
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TO SO BENETIC DISEASES (PLEASE LIST)  OF SO B D SO OSTEOPOROSIS OR OTHER BONE DENSITY DISEASE/CONDITION  IN THE PAST 3 MONTHS HAVE YOU HAD OR ARE YOU PEVER! CHILLS / SWEATS UNEXPLAINED WEIGHT CHANGE (MORE THAN 10 LBS) DIFFICULTY SLEEPING DUE TO PAIN CLINIC CURRENT MEDICATION LIST PLEASE INDICATE DOSAGE (IF KNOWN), FREQUENCY, AND ANY OVER-THE-COUNTER MEDICATIONS, VITAMINS/SUPPLEME DO YOU HAVE ANY MEDICATION ALLERGIES? YES NO IF SO, WHAT?  HAVE YOU PREVIOUSLY BEEN UNDER CHIROPRACTIC CARE? YES NO IF SO, WHEN?  DO YOU TOLERATE MANUAL ADJUSTING (HANDS-ON)? YES NO IF NO, PLEASE EXPLAIN	1 F	SI	В	D	S0	CIRCULATORY	CONDITION	S			
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DO YOU HAVE ANY MEDICATION ALLERGIES?		E	N TI	HE F	PAST :	3 MONTHS HAVE G:	YOU HAD O	OR ARE YOU	□ FEVE □ UNE CHA	ER / CHILLS / SW XPLAINED WEIGH NGE (MORE THAN	HT N 10 LBS) D DIFFICULTY SLEEPING DUE TO PAIN
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ARE THERE ANY PREFERENCES YOU WOULD LIKE US TO KNOW ABOUT YOUR CHIROPRACTIC CARE?	}		N TI	PH REN	PAST : ENCING YSICA IT MEI	B MONTHS HAVE  G:  L EXAM  DICATION LIST F	PRIPLEASE INDICATE	IMARY CARE P  DOSAGE (IF KNOW)	FEVIOR UNE CHAPHYSICIAN	ER / CHILLS / SW XPLAINED WEIGH NGE (MORE THAN 	TT N 10 LBS) DIFFICULTY SLEEPING DUE TO PAIN CLINIC COUNTER MEDICATIONS, VITAMINS/SUPPLEME
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ARE THERE ANY PREFERENCES TOO WOULD LIKE US TO KNOW ABOUT YOUR CHIROPRACTIC CARE!	}		N THEXPE	PH REN	PAST : ENCING YSICA IT MEI HAVE	B MONTHS HAVE  G:  L EXAM  DICATION LIST F  ANY MEDICATION  EVIOUSLY BEEN	PRIPLEASE INDICATE  ON ALLERGIE  UNDER CHI	IMARY CARE P  DOSAGE (IF KNOW!	FEVIOR UNE CHAPHYSICIAN N), FREQUENC	ER / CHILLS / SW XPLAINED WEIGH NGE (MORE THAN 	DIFFICULTY SLEEPING DUE TO PAIN  CLINIC  COUNTER MEDICATIONS, VITAMINS/SUPPLEME
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			N TI	PH REN OU E YO	PAST : ENCING YSICA IT MEI HAVE DU PRI	B MONTHS HAVE  G:  L EXAM  DICATION LIST F  ANY MEDICATION  EVIOUSLY BEEN  RATE MANUAL AI	PRIPLEASE INDICATE ON ALLERGIE UNDER CHI	IMARY CARE P  DOSAGE (IF KNOW!  SS?	☐ FEVI ☐ UNE CHA PHYSICIAN N), FREQUENC	ER / CHILLS / SW XPLAINED WEIGH NGE (MORE THAN  Y, AND ANY OVER-THE-I  IF SO, WHAT? YES □ NO I  NO IF NO, I	DIFFICULTY SLEEPING DUE TO PAIN  CLINIC  COUNTER MEDICATIONS, VITAMINS/SUPPLEME  F SO, WHEN?  PLEASE EXPLAIN

### REASON FOR TODAY'S VISIT PRIMARY COMPLAINT DESCRIBE YOUR SYMPTOMS \_\_\_\_\_ WHEN DID IT START? \_\_\_\_\_ HOW ARE YOUR SYMPTOMS GETTING GETTING NOT BETTER WORSE CHANGING CHANGING? HOW OFTEN DO YOU NOTICE THESE SYMPTOMS? □ CONSTANTLY (100% - 76%) □ FREQUENTLY (75% - 51%) □ OCCASIONALLY (50% - 26%) □ INTERMITTENTLY (25% - 0%) SECONDARY COMPLAINT DESCRIBE YOUR SYMPTOMS WHEN DID IT START? HOW ARE YOUR SYMPTOMS GETTING GETTING NOT BETTER WORSE CHANGING CHANGING? HOW OFTEN DO YOU NOTICE THESE SYMPTOMS? □ CONSTANTLY (100% - 76%) □ FREQUENTLY (75% - 51%) □ OCCASIONALLY (50% - 26%) □ INTERMITTENTLY (25% - 0%) OTHER COMPLAINT DESCRIBE YOUR SYMPTOMS \_\_\_\_ HOW ARE YOUR SYMPTOMS GETTING GETTING WHEN DID IT START? \_\_\_\_\_ NOT BETTER WORSE CHANGING CHANGING? HOW OFTEN DO YOU NOTICE THESE SYMPTOMS? □ CONSTANTLY (100% - 76%) □ FREQUENTLY (75% - 51%) □ OCCASIONALLY (50% - 26%) □ INTERMITTENTLY (25% - 0%) HISTORY OF COMPLAINT(S) RATE YOUR PAIN (0= NO PAIN, 10= UNBEARABLE PAIN) AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10 AT ITS WORST 0 1 2 3 4 5 6 7 8 9 10 WHAT MAKES YOUR SYMPTOMS BETTER? WHAT MAKES YOUR SYMPTOMS WORSE? ARE YOUR SYMPTOMS WORSE AT CERTAIN TIMES OF THE DAY? □ YES □ NO IF SO, PLEASE EXPLAIN\_\_\_\_\_ HAVE YOU BEEN SEEN BY ANYONE FOR THIS CONDITION? NO ONE PHYSICAL THERAPIST ☐ MEDICAL DOCTOR ☐ OTHER CHIROPRACTOR IF SO, DATE SEEN \_\_\_\_/\_\_\_ □ ER OTHER \_\_\_\_ HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? □ YES □ NO IF SO, WHEN \_\_\_\_\_\_

### DESCRIBE YOUR SYMPTOMS

USING THE ADJACENT BODY CHARTS, PLEASE INDICATE ALL AFFECTED AREAS AND SYMPTOMS IF YOU ARE EXPERIENCING THEM.

- //= STABBING PAIN
- B = BURNING PAIN
- D = DULL PAIN
- A = ACHING PAIN
- SW = SWELLING
- C = CRAMPS
- T = TINGLING
- ST = STIFFNESS
- N = NUMBNESS



DO YOU HAVE ANY LOSS OF BOWEL OR BLADDER CONTROL, CHANGES IN SMELL, TASTE, HEARING, VISION, SPEECH, DIFFICULTY SWALLOWING OR WITH FACIAL EXPRESSION? 

OUTPUT

VES OF BOWEL OR BLADDER CONTROL, CHANGES IN SMELL, TASTE, HEARING, VISION, SPEECH, DIFFICULTY SWALLOWING OR WITH FACIAL EXPRESSION? 
OUTPUT

VES OF BOWEL OR BLADDER CONTROL, CHANGES IN SMELL, TASTE, HEARING, VISION, SPEECH, DIFFICULTY SWALLOWING OR WITH FACIAL EXPRESSION? 
OUTPUT

VES OF BOWEL OR BLADDER CONTROL, CHANGES IN SMELL, TASTE, HEARING, VISION, SPEECH, DIFFICULTY SWALLOWING OR WITH FACIAL EXPRESSION? 
OUTPUT

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### YOUR CHIROPRACTIC CARE

WHAT ARE YOU HOPING TO ACHIEVE THROUGH CHIROPRACTIC CARE?

ARE THERE ACTIVITIES IN YOUR LIFE YOU ARE CURRENTLY UNABLE TO DO THAT YOU WOULD LIKE TO BE ABLE TO DO AGAIN? PLEASE EXPLAIN

BODY IN BALANCE



## DR. AMY KEMPFER

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# REVIEW OF SYSTEMS

PLEASE	MARK ANY OF THE CON	IDITIONS BELOW THAT APPLY TO YOU,
□ NONE □ FEVE	R WEIGHT L	NED/UNINTENTIONAL OSS/GAIN
NONE HEAD DIZZI LIGHT CHAN EYE F REDN EXCE DOUB SEEIN SORE DRY N HOAR	INJURY NESS I-HEADEDNESS IGES IN VISION PAIN IESS OF EYES SSIVE TEARING BLE OR BLURRED VISION NG SPOTS, SPECKS OR HING LIGHTS I THROAT	☐ CHANGES IN HEARING ☐ TINNITUS ☐ VERTIGO ☐ EARACHE ☐ DISCHARGE ☐ FREQUENT COLDS ☐ NASAL STUFFINESS ☐ DISCHARGE/ITCHING OF THE NOSE ☐ HAY FEVER
SKIN NONE RASH LUMF SORE BLIST GROV	ES PS ES ERS	☐ ITCHING ☐ DRYNESS ☐ CHANGES IN HAIR OR NAILS ☐ CHANGES IN SIZE OR SHAPE OF MOLES ☐ OTHER
	□ NONE □ ABNORMAL BLEEDIN	MALES  NONE HERNIAS DISCHARGE SORES PAINS MASSES STRUAL CYCLES SWELLINGS INFERTILITY ERECTILE DYSFUNCTION OTHER  C/LYMPHATIC

T OR PRESENT.
HEART/CARDIOVASCULAR  NONE CHEST PAIN OR PRESSURE ARRHYTHMIA OR PALPITATIONS SHORTNESS OF BREATH SWELLING/EDEMA BLOOD CLOTS VARICOSE VEINS CRAMPING IN THIGHS OTHER
GASTROINTESTINAL SYSTEM:  □ NONE □ ABDOMINAL PAIN □ NAUSEA □ REDUCED APPETITE □ BLOODY OR BLACK TARRY STOOL □ FREQUENT URINATION □ PAIN OR BURNING DURING URINATION □ FLANK PAIN □ OTHER
ENDOCRINE  NONE  HEAT OR COLD RESISTANCE  EXCESSIVE THIRST  EXCESSIVE HUNGER  OTHER  OTHER
PSYCHIATRIC CONDITIONS  DIAGNOSIS  NO DIAGNOSED PSYCHIATRIC CONDITIONS
NEUROLOGIC

	, , , , , , , , , , , , , , , , , , , ,	
ĺ	NONE	□ WEAKNESS
Ĺ	→ HEADACHE	□ PARALYSIS
Ĺ	□ VERTIGO	□ TREMORS
ĺ	□ FAINTING	□ SEIZURES
Ĺ	→ BLACKOUTS	□ OTHER
Ĺ	☐ NUMBNESS OR	LOSS OF SENSATION
Ĺ	□ TINGLING OR FE	EELING OF "PINS AND NEEDLES
ĺ	☐ CHANGES IN MC	OOD, ATTENTION OR SPEECH
Ĺ	☐ CHANGES IN OR	IENTATION/MEMORY/JUDGEMEN

□ NONE	□ COUGH
WHEEZING	☐ SHORTNESS OF BREATH
OTHER	

RESPIRATORY

ALLEKGIC/IMMUNULUGIC	
□ NONE □ HAY FEVER	
☐ IMMUNE DEFICIENCIES ☐ OTHER	

PATIENT SIGNATURE	DATE	1	1