Welcome to Kukurin Chiropractic Network

You made the right choice

Our office is rated one of the top chiropractic offices in America by the Consumers Research Council of America
We were voted one of the top ten offices by Who's Who of Medicine
And we have been named as one of American's Leading Professionals by Who's Who

We are very thorough, please take the time to complete this comprehensive health information booklet. We take your health seriously.
~Dr George W. Kukurin

Administrative Information

Name _____ Age Birthday

Address _____ Box _____ Social Security # - -

City _____ State _____ Zip _____ Marital Status: single married separated widowed divorced

eMail _____ @ _____ Spouses Name, if applicable

Phone # Cell _____ Home _____ _____

Work _____

How many children ? _____

Preferred method of contact [ ] cell [ ] work [ ] home [ ] eMail

Referral Information: How did you find out about our office?

[ ] Hospital [ ] Specialist [ ] Family Doctor [ ] Current patient _____ [ ] Insurance Book

[ ] Self referred [ ] Saw news about the office on television [ ] Read about the office in newspaper [ ] Radio

[ ] Yellow Pages [ ] Newsletter [ ] Mailer [ ] Internet [ ] Other _____

Work Information

[ ] Retired / currently unemployed / stay-at-home mom

Check all that apply concerning your job

Name of employer _____

[ ] computer work [ ] desk work [ ] prolonged sitting

Location _____

[ ] stress/pressure [ ] shifts exceed 8 hours [ ] standing

Supervisor _____ phone number _____

[ ] lifting [ ] bending [ ] twisting [ ] reaching

[ ] exposed to chemicals [ ] exposed to smoke

Insurance Information

Please let us copy your insurance card

[ ] currently uninsured [ ] Blue Cross/Shield [ ] United Healthcare [ ] Aetna [ ] Cigna [ ] UPMC [ ] Medicare
[ ] Health America [ ] Highmark [ ] Health America [ ] Other

Did you get hurt at work? No /Yes Describe the incident and provide the date _____

Did you report the work injury? Yes/ No _____

Did you get hurt in an auto accident? No / Yes _____

_____

Were you the [ ] driver [ ] passenger were others in the car with you? No /Yes

Please continue on the next page>>>>>

Check all that apply	Where	How bad	How often	How bothersome
Major/Current Complaints	Right / Left	N/10	25% 50% 75% 100%	none slight moderate severe
[ ] Headaches				
[ ] Neck Pain				
[ ] Upper Back Pain				
[ ] Pain near shoulder blades				
[ ] Pain in lower back				
[ ] Pain in buttocks				
[ ] Shoulder pain				
[ ] elbow pain				
[ ] Wrist/hand pain				
[ ] hip pain				
[ ] groin pain				
[ ] knee pain				
[ ] foot/ankle pain				
[ ] dizziness				
[ ] numbness in [ ] arms [ ] hands				
[ ] numbness in [ ] thighs [ ] legs				
[ ] numbness in feet				
			iSS	

Does your current problem(s) affect your

[ ] work [ ] relationship with your family [ ] hobbies [ ] sleep [ ] recreational activities

Is there a particular activity that you can not do now that you wish you could do again? _____

How long has your current problem been bothering you? _____

Is your current problem [ ] getting worse [ ] about the same [ ] slowly improving

If you continue to suffer from your current condition, describe how you think you'll be in another six months to a year?

_____

Have you consulted with any other doctors for this condition? [ ] No [ ] Yes, if yes, what medication/treatment were you given?

_____

How helpful was previous treatment [ ] not effective [ ] took the edge off [ ] helped a lot

Have you had [ ] X-Rays [ ] MRI [ ] CT Scans [ ] Nerve Tests [ ] Blood Tests or other tests for your current condition?

Please continue on the next page>>>>>

Often knowing your family history will help us to both diagnose and formulate an effective treatment plan. Please take a moment to provide us with your family history. Does anyone in your family suffer from the same or similar condition as yours?

Who/relation What problem? Type of care they received? How effective was it?

1. _____

2. _____

3._____

As a courtesy to our patients we provide free health information to friends and family. Would you like us to send them relevant brochures on how they may improve their condition ? Yes No

It is important for us to know your detailed health history so we can provide you with effective and safe treatment that is tailored to your health status. Please take the time to list those conditions that you have or have had. <u>If you have any unusual health issues that are not listed make sure you bring them to the attention of the doctor.</u>

[ ] Painful or burning urination
[ ] Frequent or night urination
[ ] Blood in urine
[ ] Dark or foul smelling urination
[ ] Trouble starting urination
[ ] Leaking / urinary incontinence
[ ] Urinary tract infections
[ ] Kidney stones
[ ] Prostate troubles / surgery
[ ] Bladder troubles / surgery

How much water or other healthful fluid do you drink per day?

___ cups

[ ] Arthritis
[ ] Rheumatoid Arthritis
[ ] Lupus
[ ] Autoimmune disease
[ ] Temporal Arteritis
[ ] Gout
[ ] Stenosis
[ ] Osteoporosis

[ ] Chronic cough
[ ] Sore throats
[ ] Fatigue
[ ] Swollen ankles
[ ] Heart palpitations

[ ] Chest pains
[ ] Light headedness
[ ] Numbness in jaw
[ ] Numbness in arm
[ ] Shortness of breath
[ ] Cramping in legs
[ ] Anemia
[ ] Heart surgery
[ ] Pace maker
[ ] Clotting Disorder
[ ] Bleeding Disorder
[ ] High Blood Pressure
[ ] Heart attack
[ ] Aneurysm
[ ] Asthma
[ ] Lung surgery
[ ] COPD
[ ] Tuberculosis
[ ] Sinus / allergies
[ ] Swollen ankles
[ ] Fatigue
[ ] Cancer
[ ] Cystitis

Are you taking any blood thinning medications?

Are you taking cholesterol lowering medications?

[ ] Abdominal pain
[ ] Acid reflex
[ ] Indigestion
[ ] Heart burn
[ ] Gall bladder disease
[ ] Diarrhea
[ ] Constipation
[ ] Blood in stool
[ ] Hemorrhoids
[ ] Colitis
[ ] Irritable bowl syndrome
[ ] Pancreatitis
[ ] Liver disease
[ ] Hepatitis
[ ] Food intolerance
[ ] Food allergies
[ ] Trouble swallowing
[ ] Ulcer
[ ] Diabetes
[ ] Crohn's Disease

[ ] Menstrual Difficulty
[ ] Miscarriages
[ ] Poly-cystic Ovaries
[ ] PMS
[ ] Hot Flashes
[ ] Menopausal Symptoms
[ ] Are you pregnant?
[ ] Endometriosis
[ ] Taking birth control pills?
[ ] Do you have breast implants?
[ ] Thyroid Problems

[ ] Headaches
[ ] Blurred Vision
[ ] Memory Loss
[ ] Multiple Sclerosis
[ ] Stroke
[ ] TIA
[ ] Parkinson's Disease
[ ] Depression
[ ] Bipolar Disorder
[ ] Schizophrenia
[ ] Herniated Disc
[ ] Carpal Tunnel Syn
[ ] seizures
[ ] ADHD
[ ] panic attacks
[ ] fainting
[ ] addiction
[ ] anorexia
[ ] bulimia
[ ] fibromyalgia

[ ] recurrent infection
[ ] HIV/AIDs
[ ] sinus infections
[ ] swollen lymph nodes
[ ] rashes
[ ] dermatitis
[ ] cancer
[ ] leukemia
[ ] recurrent fever
[ ] Herpes

Habits

Smoke No Yes PPD Alcohol No Yes Caffeinated Drinks per day ___ Recreational drugs No Yes Exercise No Yes	How often do you exercise? Never Rarely Occasionally Frequently	What is your usual weight? Lbs. Has your weight been: [ ]Increasing [ ]Decreasing [ ] Stable What is your height? Feet Inches

Please continue on the next page>>>>>

Medications: Many medications produce side effects, knowing what medications you are taking may help us determine what is wrong with you and will certainly modify many of the recommendations we may offer to you. Please take a few minutes to list your medications so we can take better care of you.

Vitamins: Providing our patients with up-to date information on diet, nutrition and supplements is a big part of what we do for our patients. Please take the time to list all supplements that you are currently taking, so we may coordinate our care and recommendations with your current nutritional program.

Family Doctor: Most of our patients are referred to us by their family doctor or some other health care specialist. As a professional courtesy we like to send a report of our findings to our patient's primary care provider and also request the results of their examination findings. Please take the time to list your primary care provider and if possible provide their address and phone number.

Surgeries / Fractures: Many surgeries and some fractures will change the way we approach our management of your condition, please take a moment to list any and all surgeries you have had and also any broken or fractured bones you have experienced.

Goals of care: We treat many types of patients that have various goals for their care. Please check all of the boxes below that apply to your health care goals.

[X] Quick fix. I want to get out of pain quickly
[ ] Rehab/Exercise: I want to know how to take care of my body, and learn how to keep it functioning after the pain is gone
[ ] I'd like guidance on diet, nutrition and supplements I can take to get and stay healthy.
[ ] I am interesting in learning stress reduction methods
[ ] I'm interested in learning about tests that I can take to determine what I need to get and stay healthy.
[ ] I'm interested in weight loss advice
[ ] Other, please describe...

I certify that the information provided is true and correct to the best of my knowledge. Initials _____

I have received a Risk/Benefit Brochure /analysis. Initials _____

I authorize the Drs. of Kukurin Chiropractic to examine and treat me in accordance with applicable state laws Initials _____

I have been advised of my privacy rights under HIPPA Initials _____

I authorize the doctors of Kukurin Chiropractic to obtain any and all medical records deemed necessary for the proper diagnosis and treatment of my condition Initials _____

Signed and dated

Guardian, if patient is under 18 years old. Dated