# Kinetic Integration

Manual Therapy and Performance

Date: _____

Last Name: _____ First Name: _____ Gender: Female / Male

Date of Birth *(mm/dd/yyyy)*: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ (Home / Mobile) Email: _____

Occupation: _____

Emergency Contact:
Name: _____ Phone Number: _____

How did you hear about us? _____

Occupational Activities

| | | | | |
|---|---|---|---|---|
| ▫ Administration | ▫ Construction | ▫ Healthcare | ▫ Retail Worker | ▫ Retired |
| ▫ Business Owner | ▫ Daycare/Childcare | ▫ Heavy Equipment | ▫ Truck Driver | |
| ▫ Clerical/Secretarial | ▫ Executive/Legal | ▫ Heavy Manual Labor | ▫ Teacher | |
| ▫ Computer User | ▫ Food Service Industry | ▫ Home Services | ▫ Student | |

Recreational Activities

| | | | | |
|---|---|---|---|---|
| ▫ Hiking/Backpacking | ▫ Baseball/Softball | ▫ Gymnastics | ▫ Running | ▫ Tennis |
| ▫ Lacrosse/Field Hockey | ▫ Dance/Ballet | ▫ Martial Arts | ▫ Walking | ▫ Soccer |
| ▫ Skiing/Snowboarding | ▫ Weightlifting | ▫ Swimming | ▫ Yoga | ▫ Racquetball |

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Patient Name: _____ Date: _____

## Review of Systems

In each area, if you are not having any difficulties, please circle "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE ALL THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask.

**General Health:**
*No Problems*
Lack of energy
Unexplained weight gain/loss
Loss of appetite
Fever
Night sweats
Pain in jaws when eating
Scalp tenderness
Prior diagnosis of cancer
Other: _____

**Ears, Nose, Mouth & Throat:**
*No Problems*
Difficulty with hearing
Sinus problems
runny nose
post-nasal drip
ringing in ears
mouth sores
loose teeth
ear pain
nosebleeds
sore throat
facial pain or numbness
Other: _____

**Cardiovascular:**
*No Problems*
Irregular heartbeat
racing heart
chest pains
swelling of feet or legs
pain in legs with walking
Other: _____

**Respiratory**
*No Problems*
Shortness of breath
night sweats
prolonged cough
wheezing
sputum production
prior tuberculosis
pleurisy
oxygen at home
coughing up blood
abnormal chest x-ray
Other: _____

**Gastrointestinal:**
*No Problems*
Heartburn
constipation
intolerance to certain foods
diarrhea
abdominal pain
difficulty swallowing
nausea
vomiting
blood in stools
unexplained change in bowel habits
incontinence
Other: _____

**Genitourinary:**
*No Problems*
Painful urination
frequent urination
urgency
prostate problems
bladder problems
Other: _____

**Musculoskeletal:**
*No Problems*
Joint pain
aching muscles
shoulder pain
swelling of joints
joint deformities
back pain
Other: _____

**Integumentary:**
*No Problems*
Persistent rash
Itching
new skin lesion
change in existing skin lesion
hair loss or increase
breast changes
Other: _____

**Endocrinologic:**
*No Problems*
Intolerance to heat or cold
menstrual irregularities
frequent hunger/urination/thirst
changes in sex drive
Other: _____

**Allergic/Immunologic:**
*No Problems*
Seasonal allergies
hay fever symptoms
itching
frequent infections
Other: _____

**Neurologic:**
*No Problems*
Frequent headaches
double vision
weakness
change in sensation
problems with walking or balance
dizziness
tremor
loss of consciousness
uncontrolled motions
episodes of visual loss
Other: _____

**Psychiatric:**
*No Problems*
Insomnia
Irritability
Depression
Anxiety
recurrent bad thoughts
mood swings
hallucinations
compulsions
Other: _____

**Hematologic:**
*No Problems*
Easy bleeding
easy bruising
anemia
abnormal blood tests
leukemia
unexplained swollen areas
Other: _____

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Patient Name: _____ Date: _____

Past History:

Any prior surgeries? *(Type & Year):* _____

Any major accidents or injuries? *(Type/Year)*: _____

Any allergies? _____

Current Medications: _____

Current Supplements: _____

Current complaint: _____ Height: _____ Weight: _____

When did the current symptoms begin? _____

What caused/lead to the current symptoms? _____

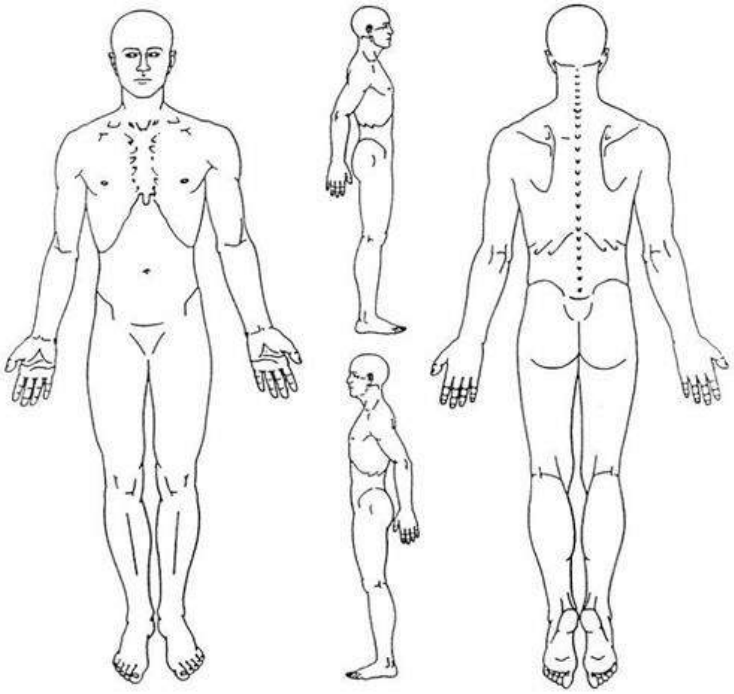
**Circle the types of symptoms you are currently experiencing**

**SYMPTOMS**

Dull Ache
Sharp/Shooting
Pain with Movement
Numbness
Tingling
Radiating Pain
Burning
Throbbing
Stiffness
Weakness
Redness
Inflammation
Swelling/Edema
Other: _____

_____

**Draw your symptoms on the diagram below.**



What is the current intensity of your symptoms?

▢0 (no pain) ▢1 ▢ 2 ▢ 3 ▢ 4 ▢ 5 ▢ 6 ▢ 7 ▢ 8 ▢ 9 ▢ 10 (worst pain)

What is the most intense the symptoms have been? When did this occur? _____

▢0 (no pain) ▢1 ▢ 2 ▢ 3 ▢ 4 ▢ 5 ▢ 6 ▢ 7 ▢ 8 ▢ 9 ▢ 10 (worst pain)

How often do you experience your current symptoms during the day?

▢ Intermittent (0-25%) ▢ Occasional (26-50%) ▢ Frequent (51-75%) ▢ Constant (76-100%)

Since the symptoms started, are they:

▢ Getting Better ▢ Not Changing ▢Getting Worse

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Patient Name: _____ Date: _____

What, if anything, seems to make your symptoms worse?

_____

_____

What, if anything, seems to make your symptoms better?

_____

_____

What treatment, if any, have you received for your current symptoms? *Yes / No*

If yes, what treatment have you received? and when did you receive this treatment?

_____

_____

Have you had any imaging or specialized testing for your current symptoms? Yes / No

If yes, what imaging and/or testing have you had and when was it performed?

_____

_____

Have you had similar symptoms in the past? Yes / No

If yes, what treatment did you receive: _____

What are your treatment goals:

_____

_____

_____

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## Consent To Treatment

I hereby request and consent to the performance of massage therapy or chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date _____

Print Name: _____

Parent or Guardian (If a Minor): _____

## Authorization to Treat a Minor

As a parent or legal guardian of _____, I hereby consent, authorize and request Dr. Drew Hohensee, DC to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold him/her free and harmless from any claims, suits for damages or complications which may result from such treatment.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Parent or Guardian | Relationship to the Patient | Date |