



Klein Chiropractic Center
 821 West Chester Pike
 West Chester, PA 19382
 www.kleinchirocenter.com
 (610) 918-9455

Name _____ Age _____ Date _____

Phone (home) _____ Phone (cell) _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Hours/Week Currently Working _____

How were you referred to our office? _____

Check off any of the following symptoms you have experienced in the past six months:

- | | | |
|---------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Numbness/Tingling in Hands |
| <input type="checkbox"/> Pain b/t Shoulder Blades | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Numbness/Tingling in Feet |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Tension/Headache | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Wrist/Hand Pain | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Weight Trouble | <input type="checkbox"/> Tension in Shoulders | <input type="checkbox"/> Other _____ |

Which of the above is the worst? _____

How long have you had this problem? _____

When it is as its worst, how does it feel? _____

List all types of surgeries with the date: _____

Are you currently going through Chemo-therapy? Yes No

Are you currently pregnant? Yes No If so, how far along are you? _____

Are you on any pain medications at this time? If so, which ones? _____

- | | | |
|--------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------|
| Does this cause you to be: | Does this affect your work: | Does this affect your life: |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Decision Making | <input type="checkbox"/> Lose patience with spouse/kids |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Poor attitude | <input type="checkbox"/> Restricted house duties |
| <input type="checkbox"/> Interrupt sleep | <input type="checkbox"/> Decreased productivity | <input type="checkbox"/> Ability to participate in sports |
| <input type="checkbox"/> Restrict daily activity | <input type="checkbox"/> Exhausted at the end of day | <input type="checkbox"/> Ability to exercise daily |

If You've Checked Any of the Above Items, You May Be Suffering From:
Excessive Stress Structural Misalignment Pinched Nerves

CHIROPRACTIC CAN HELP YOU! Chiropractic doctors gently treat the body naturally, without drugs, to remove the stress and imbalances that cause health problems.

Would you like to get rid of the problem and:

- Schedule an appointment with the doctor for a FREE complete evaluation
- Have the doctor contact you to discuss chiropractic care and your health options

"We are dedicated to helping people reach optimal health through natural chiropractic care"