KHALSA
Pain Relief Clinic, P.C.

Khalsa Pain Relief Clinic, P.C.
5013 SE Hawthorne Blvd.
Portland, OR 97215
503-238-1032

About You

Today's Date: ___/____/_____

Patient: _____
Last First MI

Name you prefer _____

Birthdate: ___/___/____ Age: _____

Gender: _____

SS#: _____

Mailing Address: _____

_____

City _____

State _____ Zip _____

Home Phone: _____

Work Phone: _____

Other Phone: _____

E-mail: _____

Referred By: _____

Employer: _____

Employer Address: _____

_____

Marital Status: ❑ S ❑ M ❑ W ❑ D ❑ DP

Name of Spouse _____

Number of Children_____

Spouse's Address _____

Spouse Telephone _____

Spouse's Occupation _____

Emergency Contact _____

Telephone _____

Person responsible for payment: ❑ Self

_____

Address:_____

_____

Phone: _____

Past History

Past chiropractic care? Yes ❑ No ❑

If yes, who/where? _____

Name & phone# of your primary care physician?

_____

_____

Last Physical Examination ___/____/_____

Have you been treated for any health condition by a physician within the last year? Yes ❑ No ❑

If yes, explain _____

_____

_____

What medication(s) are you taking? _____

_____

Have ever had:	Surgery	Yes ❑ No ❑
	Fractures	Yes ❑ No ❑
	Car Accidents	Yes ❑ No ❑
	Falls	Yes ❑ No ❑
	On-Job Injury	Yes ❑ No ❑

Describe: _____

_____

Family history of:	Heart disease	Yes ❑ No ❑
	Cancer	Yes ❑ No ❑
	Diabetes	Yes ❑ No ❑
	Arthritis	Yes ❑ No ❑
	Back problems	Yes ❑ No ❑

Other: _____

Previous serious illness/ hospitalization:

(Please date & describe) _____

_____

_____

If you are female, are you possibly pregnant?
Yes ❑ No ❑

Date of last menstrual period _____

Current Condition

❑ Emergency ❑ New Injury ❑ Old Injury ❑ Chronic Pn ❑ Wellness

Major Symptom _____

_____

_____

Date symptoms first began: ___/___/_____

How did your symptoms first begin? _____

_____

_____

Other Symptoms _____

_____

Pains is: ❑ Constant ❑ Intermittent

Is your condition getting? ❑ Worse ❑ Better ❑ Same

What activities aggravate your condition?_____

_____

What activities lessen your symptoms? _____

_____

Is condition worse during certain times of the day?

_____

Is this condition interfering with:

work ❑ Yes ❑ No

sleep ❑ Yes ❑ No

routine ❑ Yes ❑ No

Other doctors seen for this condition _____

_____

_____

List home remedies tried _____

_____

_____

Other Health Conditions

Have you ever had (P - Past) or do now have (C - Current) any of the following?

Constitutional		**Genitourinary**	
Fatigue or Weakness	❑ P ❑ C	Blood in Urine	❑ P ❑ C
Fever	❑ P ❑ C	Bladder Leakage	❑ P ❑ C
Eyes		Burning Freq. Urination	❑ P ❑ C
Glaucoma	❑ P ❑ C	Kidney Trouble	❑ P ❑ C
Cataracts	❑ P ❑ C	Abnormal Menstruation	❑ P ❑ C
Double Vision	❑ P ❑ C	Prostate Problems	❑ P ❑ C
Ears, Nose, Throat		Sexual Dysfunction	❑ P ❑ C
Difficulty Hearing	❑ P ❑ C	**Cardiovascular**	
Buzzing or Ringing in Ears	❑ P ❑ C	Chest Pain	❑ P ❑ C
Dizziness/Light Headed	❑ P ❑ C	Shortness of Breath	❑ P ❑ C
Loss of Smell	❑ P ❑ C	Heart Trouble or Stroke	❑ P ❑ C
Loss of Taste	❑ P ❑ C	High Blood Pressure	❑ P ❑ C
Sinus Prob. or Allergies	❑ P ❑ C	Racing Heartbeat	❑ P ❑ C
Skin		Fainting	❑ P ❑ C
Rashes	❑ P ❑ C	Leg Cramps or Swelling	❑ P ❑ C
Hives	❑ P ❑ C	**Neurological**	
Itching	❑ P ❑ C	Headaches	❑ P ❑ C
Allergic/Immunologic		Convulsions	❑ P ❑ C
Hay Fever/Hives	❑ P ❑ C	Seizures	❑ P ❑ C
Respiratory		Loss of Balance or Coordin.	❑ P ❑ C
Cough/Flu/Cold	❑ P ❑ C	Loss of Energy	❑ P ❑ C
Cough Blood	❑ P ❑ C	Loss of Memory	❑ P ❑ C
Wheezing	❑ P ❑ C	Numbness in Toes/Fingers	❑ P ❑ C
Tuberculosis	❑ P ❑ C	**Mental Status**	
Pneumonia	❑ P ❑ C	Depression	❑ P ❑ C
Pain or Diff. Breathing	❑ P ❑ C	Anxiety	❑ P ❑ C
Asthma or Emphysema	❑ P ❑ C	Nervousness	❑ P ❑ C
Gastrointestinal		Sleeping Problems	❑ P ❑ C
Nausea or Vomiting	❑ P ❑ C	Tension or Irritability	❑ P ❑ C
Constipation/Diarrhea	❑ P ❑ C	**Endocrine**	
Digestive/Eating Probs:	❑ P ❑ C	Thyroid Problems	❑ P ❑ C
Blood in Stool	❑ P ❑ C	Diabetes	❑ P ❑ C
Musculoskeletal		Hair Loss	❑ P ❑ C
Spinal Pain	❑ P ❑ C	Hot/Cold Intollerance	❑ P ❑ C
Joint Swelling	❑ P ❑ C	Change Appetie	❑ P ❑ C
Joint Stiffness	❑ P ❑ C	Excessive Sweating	❑ P ❑ C
Arthritis or Bursitis	❑ P ❑ C	**Hematologic/Lymphatic**	
		Anemia	❑ P ❑ C
		Ease of Bruising	❑ P ❑ C
		Gum Bleeding	❑ P ❑ C
		Enlarged Glands	❑ P ❑ C

Check if you have had any of the following in the last 30 days:

- ❑ Pain worse at night
- ❑ Constant pain unrelated to motion
- ❑ Unexplained weight loss
- ❑ Loss of bowel/bladder control
- ❑ Bacterial infection
- ❑ Surgery
- ❑ Fever or chills
- ❑ Visit to ER, Urgent Care or Hospital

Check if you have ever had any of the following:

- ❑ History of Cancer
- ❑ History of HIV
- ❑ Use of Steroids
- ❑ Use of IV Drugs
- ❑ Blood Transfusions

Lifestyle.

Do you? ❑ Smoke ❑ Abuse alcohol ❑ Use rec. drugs

Exercise Level: ❑ Heavy ❑ Moderate ❑ Light ❑ Non-existant

Diet Quality: ❑ Good ❑ Average ❑ Poor ❑ Veg. - Vegan

Stress Level: ❑ High ❑ Average ❑ Low

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information pertinent to my case to the insurance company.

Signature _____ **Date** _____

❑ Adult Patient ❑ Parent/Guardian ❑ Spouse

(office use) ❑ ID: _____