



We look forward to meeting you at Compass Chiropractic!

Dr. Krohse at Compass Chiropractic has a reputation for performing the most thorough exam to determine all the causes of your pain or condition. In order to make your first visit as efficient and effective as possible please take a look at the following checklist:

Before your visit:

- Previous Imaging: Contact Compass Chiropractic if you have had X-Rays, MRI's, or other imaging of the problem area performed within the last two years to find out if you should pick them up ahead of time.
- Automobile and Work Injuries: Contact Compass Chiropractic if you consider your injury to be caused by a car accident or work injury to find out what extra paperwork you may be able to fill out before your visit.
- Paperwork: Fill out the attached paperwork. If you forget your paperwork the day of your visit, please plan to arrive 10 minutes earlier than your scheduled visit to allow time to fill out paperwork.

Bring the day of your visit:

- Filled out paperwork
- Previous imaging if applicable
- Any applicable insurance card/cards
- Cash, check, or credit/debit card to cover your financial responsibility
- * Toys and books are available to keep your little ones occupied during your first visit if needed

Directions:

From 80/35 South and 35 North

1. Exit University Ave
2. Turn west onto University heading **away** from downtown Des Moines
3. Turn right after ~ 6 blocks at 124th St at the **Boston's Rest**.
4. See Compass Chiropractic one block up 124th on the same side of the street as the Boston's Restaurant

From 235 Traveling West

1. Take exit 123B for Minneapolis
2. Curve right to exit to University Avenue
3. Turn left onto University
4. Turn right after ~ 8 blocks at 124th St at the **Boston's Rest**.
5. See Compass Chiropractic one block up 124th on the same side of the street as the Boston's Restaurant

From University Ave Traveling East from Jordan Creek Pkwy

1. Pass Granite City and Biaggi's at 60th/128th
2. Turn left after - 4 blocks at 124th St by the **Boston's Rest**.
3. See Compass Chiropractic one block up 124th on the same side of the street as the Boston's Restaurant



Dr. David Krohse
P: 515.309.1217

12337 Stratford Drive
Clive, IA 50325

Chiropractic Case History/Patient Information

Date: _____

Patient # _____

PERSONAL INFORMATION

Name: First _____ Preferred _____ MI _____ Last _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: _____ Home Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D Social Security # _____

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Emergency Contact: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto ___ Work ___ Other _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

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

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____



Date: _____ Patient Name: _____ Patient # _____

PAST MEDICAL HISTORY

Check the following conditions you have had:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever | _____ |

REVIEW OF SYSTEMS

Check any of the following symptoms you have now (N) or had in the Past (P)

- | | | | | | |
|----------|----------|---------------------------------|----------|----------|---|
| N | P | General | N | P | Eyes, Ears, Nose, Throat |
| ___ | ___ | Severe or frequent headaches | ___ | ___ | Deafness |
| ___ | ___ | Sinus Infections | ___ | ___ | Earache |
| ___ | ___ | Frequent Colds | ___ | ___ | Eye Pain |
| ___ | ___ | Depression | ___ | ___ | Hay Fever |
| ___ | ___ | Loss of Sleep | ___ | ___ | Sore Throat |
| ___ | ___ | Loss of Weight | ___ | ___ | Nasal Obstruction |
| ___ | ___ | Nervousness | ___ | ___ | Hoarseness |
| ___ | ___ | Tremors | ___ | ___ | Nosebleeds |
| ___ | ___ | Arthritis | | | Cardiovascular |
| ___ | ___ | Bursitis | ___ | ___ | High Blood Pressure |
| ___ | ___ | Dizziness | ___ | ___ | Low Blood Pressure |
| | | Pain/Numbness in: | ___ | ___ | Cold Hand/Feet |
| ___ | ___ | Neck | ___ | ___ | Heart Surgery/Pacemaker |
| ___ | ___ | Upper Back | ___ | ___ | Rapid/Slow Beating Heart |
| ___ | ___ | Shoulders | ___ | ___ | Swelling Ankles |
| ___ | ___ | Elbows | ___ | ___ | Varicose Veins |
| ___ | ___ | Hands | | | Respiratory |
| ___ | ___ | Lower Back | ___ | ___ | Chest Pain |
| ___ | ___ | Hips | ___ | ___ | Chronic Cough |
| ___ | ___ | Legs | ___ | ___ | Difficulty Breathing |
| ___ | ___ | Knees | ___ | ___ | Wheezing |
| ___ | ___ | Feet | | | Genito-Urinary |
| ___ | ___ | Sciatica (down back of leg) | ___ | ___ | Bed Wetting |
| | | Gastro-Intestinal | ___ | ___ | Blood/Pus in Urine |
| ___ | ___ | Belching/Gas | ___ | ___ | Frequent Urination |
| ___ | ___ | Ulcer/Colitis | ___ | ___ | Can't Control Urine |
| ___ | ___ | Constipation | ___ | ___ | Painful Urination |
| ___ | ___ | Diarrhea | ___ | ___ | Prostate Trouble |
| ___ | ___ | Liver Trouble | | | For Women Only |
| ___ | ___ | Gall Bladder Trouble | ___ | ___ | Cramps or Backache |
| ___ | ___ | Acid Reflux/Difficult Digestion | ___ | ___ | Excessive Flow/Discharge |
| ___ | ___ | Jaundice | ___ | ___ | Hot Flashes (Menopausal Symptoms) |
| | | Skin | ___ | ___ | Irregular Cycle/ Painful Menses |
| ___ | ___ | Bruise Easily | ___ | ___ | Miscarriage |
| ___ | ___ | Hives or Allergy | | | Are you pregnant? Yes _____ No _____ |
| ___ | ___ | Itching or Rashes | | | |



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Date: _____ Patient Name: _____ Patient # _____

SOCIAL HISTORY

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? ___ Do you smoke? ___ If so, packs per day: _____
Do you take vitamin supplements? ___ If so, please list: _____
Sleeping Position (s): Back Side fetal position side/front sprawled out front head turned front face down
Do you exercise? _____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting _____ sitting _____ bending _____ working at a computer _____

FAMILY HISTORY

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **C**hild/Children, **H**usband, **W**ife):

Back Problems _____	Cancer _____	Mental Illness _____
Neck Problems _____	Asthma _____	Heart Disease _____
Headaches _____	Kidney/Liver Disease _____	Lung Disease _____
Arthritis _____	Diabetes _____	Tuberculosis _____
Other _____		

PRIOR EXPERIENCE & NUTRITIONAL CONSULTATION OPT IN/OUT

Previous Chiropractic Experience: Positive _____ Negative _____ None _____
Comments: _____

Are you interested in discussing nutritional improvement/supplementation options to support your body's healing potential? Yes _____ No _____

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical Worker's Compensation Medicaid Medicare Auto Accident
- Medical Savings Account & Flex Plans Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

E-NEWSLETTER CONSENT


May we have permission to periodically email you Compass Chiropractic newsletters (An option to stop receiving newsletters will be on every email) Yes No

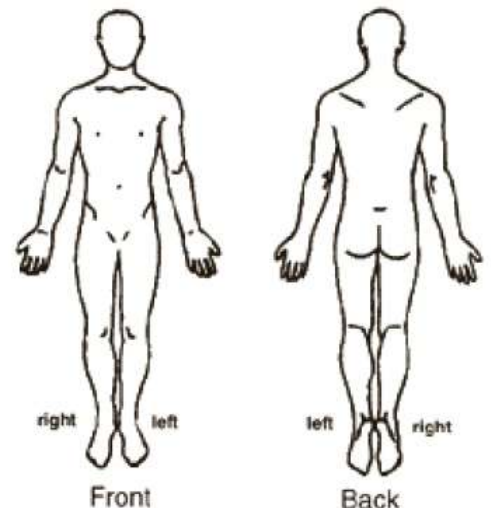
SUMMARY

Date: _____ Patient Name: _____ Patient # _____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No _____. If yes, describe: _____
Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____
6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Walking ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
11. Please circle your overall pain level below. On the right, label the areas of discomfort with a letter descriptor, and a number pain rating for each area like the sample.

Overall Pain Scale										
Please circle the number that best describes your pain										
0	1	2	3	4	5	6	7	8	9	10
NONE		LITTLE			MEDIUM				SEVERE	

Pain Diagram Key		Sample:
A = Aching	N = Numb	
B = Burning	T = Tingle	
S = Stabbing		



Remarks: _____

Doctor's Signature _____ Date _____