



## 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 124<sup>th</sup> St at the **Boston's Rest**.
4. See Compass Chiropractic one block up 124<sup>th</sup> 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 124<sup>th</sup> St at the **Boston's Rest**.
5. See Compass Chiropractic one block up 124<sup>th</sup> 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 60<sup>th</sup>/128<sup>th</sup>
2. Turn left after - 4 blocks at 124<sup>th</sup> St by the **Boston's Rest**.
3. See Compass Chiropractic one block up 124<sup>th</sup> 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: \_\_\_\_\_



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**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)

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



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### 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 _____		

### Previous Experience

Previous Chiropractic Experience: Positive \_\_\_\_\_ Negative \_\_\_\_\_ None \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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

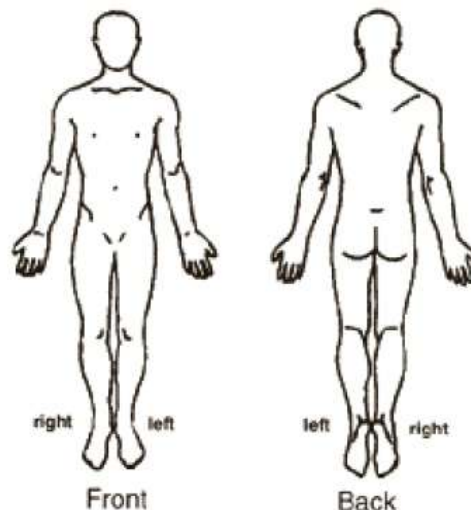
## SUMMARY

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										
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
NONE		LITTLE			MEDIUM				SEVERE	

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



Remarks: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_