Back Pain, Neck Pain & Headache Relief Center

MARK S. KIMES, D.C., CHIROPRACTIC INC.

A BrainRevive Clinic™

Patient Information

Name _____ Address _____

City _____ State _____ Zip _____ Cell # _____

Your occupation _____ Email (for confirming appointments) _____

SSN _____ Date of Birth _____ Age _____ Height _____ Weight _____

Male □ Female □ Single □ Married □ # of children _____ Name of spouse _____

Health History

List all healthcare providers, facilities, and hospitals visited in the past 12 months. _____

_____ _____ _____

Have you ever had Chiropractic care? ☐ Yes □ No If Yes, Dr. name: _____ Date of Last Visit _____

List primary reasons for your visit (health problems, pain or symptoms) in order of severity.

_____ For how long? _____

_____ For how long? _____

_____ For how long? _____

_____ For how long? _____

Has this been getting ☐ worse or □ staying the same?

What activities, incidents, or events may have contributed to your current condition? Please explain: _____

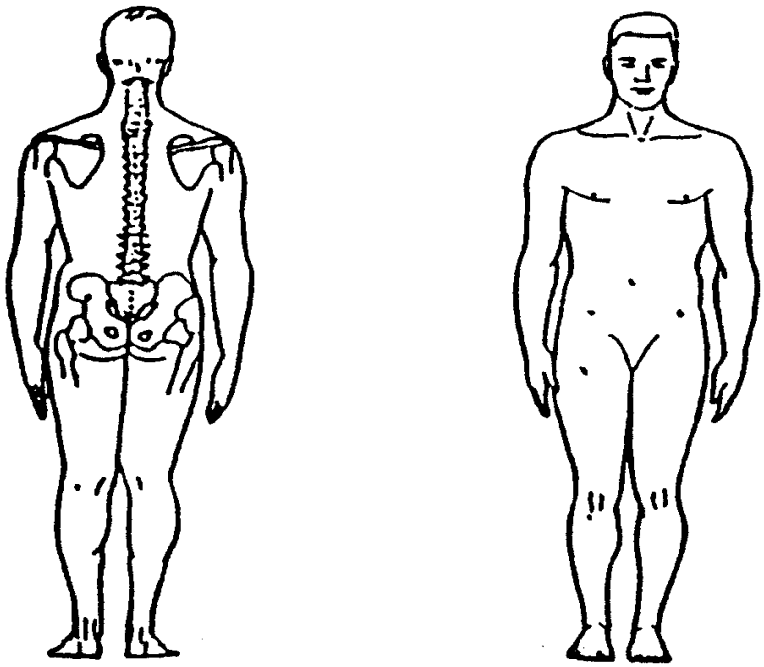
_____

Have you been involved in an auto accident in the last 12 months? □ Yes □ No If yes, accident date: _____

List all prior surgeries and dates: _____ _____

_____ _____ _____

If you are experiencing any pain or symptoms, circle the exact locations on the diagram below.



Brain Health (Check all that apply.)

- □ Brain Fog
- □ Poor focus or attention
- □ Mental fatigue
- □ Memory difficulties
- □ Distractibility
- □ Slower thinking speed
- □ Difficulty processing information
- □ Low motivation
- □ Reduced Mental Clarity
- □ Feeling mentally overwhelmed
- □ Hypervigilance
- □ Anxiety or nervousness
- □ Reduced cognitive endurance
- □ Mood swings
- □ Short tempered
- □ Rumination/repetitive negative thinking
- □ Sleep difficulty
- □ Relationship difficulties
- □ Easily frustrated
- □ Daytime fatigue
- □ Light sensitivity
- □ Noise sensitivity
- □ Headaches
- □ Dizziness
- □ Vertigo
- □ Neuropathy
- □ Loss of balance/equilibrium
- □ Stress overload
- □ Difficulty multitasking
- □ (PTS) Post-traumatic stress

Brain & Neurological History (Check all that apply.)

- □ Concussion/head injury
- □ Chronic stress
- □ Emotional trauma/stress
- □ Learning difficulties
- □ Childhood behavioral problems
- □ Long COVID symptoms
- □ Lyme disease
- □ Fibromyalgia
- □ Chronic fatigue syndrome
- □ Rheumatoid arthritis
- □ Seizures
- □ ADD (attention deficit disorder)
- □ ADHD (attention deficit hyperactivity disorder)

How would you rate your current stress level? □ Low □ Moderate □ High □ Severe

Any other conditions you'd like us to know? _____

Patient Signature _____ Date _____