



Confidential New Patient Information

Print Name _____ Date _____

Name you would like to be called _____

Email _____

Street Address _____

City _____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____

Date of Birth _____ Age _____ Social Security # _____

Your Occupation _____ Work Duties _____

How did you hear about the office? _____

Marital Status Married _____ Single _____ Divorced _____ Widowed _____

Sex Male _____ Female _____

Number of children _____ Age of children _____

Emergency Contact

Name _____ Relationship _____

Cell # _____ Home # _____

Insurance Information

If you have insurance information please provide the staff with your card.

Insurance Patients I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature _____ Date _____

Patients Without Insurance Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience.

Let us know which one you prefer. (check one) _____ Payment at time of service _____ Payment Plan

Patient's Signature _____ Date _____

(signature of parent or guardian if the patient is a minor)

Name _____ Date _____

Medical History – Section 1

Height _____ Weight _____

Have you ever been to a Chiropractor before? YES _____ NO _____

If YES Doctor's Name: _____

Date of last Chiropractic visit: _____ Reason for Care: _____

Who is your Primary Care Physician _____ Phone # _____

List any Conditions you are currently being treated for: _____

FEMALES ONLY: Is there a possibility you are pregnant? YES _____ NO _____

Have you had a DEXA Scan? YES _____ NO _____ If so, when? _____

Have you had a Vitamin D Test? YES _____ NO _____

Smoking _____ Current Every Day Smoker _____ Current Some Days Smoker
 _____ Former Smoker (> than 100 Cigarettes in Lifetime) _____ Never Smoked

Please check if you have had or currently have

Fractures _____ Osteopenia _____ Osteoporosis _____
 Heart Problems _____ Cancer _____ Blood Disorder/Clotting _____

If you have had the following, or if you suffer from the following, please Check!

| Condition, Symptom or Problem | Constantly or Frequently | Sometimes or Occasionally | Condition, Symptom or Problem | Constantly or Frequently | Sometimes or Occasionally |
|-------------------------------|--------------------------|---------------------------|-------------------------------|--------------------------|---------------------------|
| Headache | ___ | ___ | Nervousness | ___ | ___ |
| Migraines | ___ | ___ | Vision Changes | ___ | ___ |
| Neck Pain | ___ | ___ | Nose Bleeds | ___ | ___ |
| Shoulder Pain | ___ | ___ | Ringing in Ears | ___ | ___ |
| Arm/Hand Pain | ___ | ___ | Earaches | ___ | ___ |
| Mid Back Pain | ___ | ___ | Hearing Loss | ___ | ___ |
| Low Back Pain | ___ | ___ | Cough | ___ | ___ |
| Hip Pain | ___ | ___ | Chest Pains | ___ | ___ |
| Leg/Foot Pain | ___ | ___ | Female Problems | ___ | ___ |
| Disc Problems | ___ | ___ | Insomnia | ___ | ___ |
| Arthritis | ___ | ___ | Asthma | ___ | ___ |
| Other Joint Pain | ___ | ___ | Fatigue | ___ | ___ |
| Numbness | ___ | ___ | Frequent Colds | ___ | ___ |
| Joint Swelling | ___ | ___ | Diabetes | ___ | ___ |
| Dizziness | ___ | ___ | Hypoglycemia | ___ | ___ |
| Nausea | ___ | ___ | Digestive Problem | ___ | ___ |

Name _____ Date _____

Medical History – Section 2

Medications YES _____ NO _____ If YES, please list current medication(s) prescription and over-the-counter

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Drug Allergies YES _____ NO _____ If YES, please list below

- 1. _____ 2. _____

Surgeries YES _____ NO _____ If YES, please list type and date

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Past Accidents YES _____ NO _____ If YES, please list type and date

- 1. _____ 3. _____
- 2. _____ 4. _____

Other Medical History _____

In general would you say your health is? (circle your answer)

- 1 - Excellent 2- Very Good 3 - Good 4 - Fair 5 – Poor

Compared to one year ago, how would you rate your health in general? (circle your answer)

- 1 - Much better 2 - Somewhat better 3 - About the same 4 - Somewhat worse 5 - Much worse



Patient Symptoms Questionnaire

Please Print

Patient Name: _____ **Date:** _____

Symptoms

1. What is your number-one problem or the one area of greatest pain? _____

2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. **0 1 2 3 4 5 6 7 8 9 10**
3. When did this problem/pain start? _____ Gradual Sudden Progressive
4. What do you think caused this problem? _____
5. How often do you experience the pain?
 1-2 hours per day About half of the day Most of the day The pain never goes away
6. How does the pain affect your daily activities?
 It does not affect my daily activities I have had to change how I do things
 I have had to stop doing some of my daily activities I am unable to perform daily activities
7. What increases your pain? _____
8. What decreases your pain? _____
9. Have you ever experienced this problem before? **Y N** When? _____
10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.
 - a. _____ 0 1 2 3 4 5 6 7 8 9 10
 - b. _____ 0 1 2 3 4 5 6 7 8 9 10
 - c. _____ 0 1 2 3 4 5 6 7 8 9 10
 - d. _____ 0 1 2 3 4 5 6 7 8 9 10

If you have experienced any of the following conditions in the **past** mark a **"P"** on the line provided. If you are **currently experiencing** any of the following conditions please mark a **"C"** on the line provided. (check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> stroke | <input type="checkbox"/> arthritis | <input type="checkbox"/> gall bladder trouble |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> glaucoma | <input type="checkbox"/> fainting spells | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> difficulty with urination | <input type="checkbox"/> bloody stools | <input type="checkbox"/> difficulty with bowel movements | |
| <input type="checkbox"/> prostate trouble | <input type="checkbox"/> anemia | <input type="checkbox"/> cancer | <input type="checkbox"/> asthma |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> ulcers | <input type="checkbox"/> diverticulosis | <input type="checkbox"/> menstrual cramping |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of memory | <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> general fatigue | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> nausea | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> soreness in joints | <input type="checkbox"/> loss of hearing |
| <input type="checkbox"/> ears ringing | <input type="checkbox"/> headache | <input type="checkbox"/> migraine | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> gout | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> syphilis | <input type="checkbox"/> sprained ankle R L |
| <input type="checkbox"/> knee/hip replacement | | <input type="checkbox"/> broken bones (specify) _____ | |



Patient Symptoms Questionnaire (cont.)

Please Print

Patient Name: _____ **Date:** _____

General Activities (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed | <input type="checkbox"/> fall asleep in recliner/on couch |
| <input type="checkbox"/> sleep on stomach | <input type="checkbox"/> use two or more pillows to sleep with | |
| <input type="checkbox"/> needlepoint/knitting | <input type="checkbox"/> sewing | |
| <input type="checkbox"/> lift weights/wt. mach. | <input type="checkbox"/> play video games (___ hrs per day) | |
| <input type="checkbox"/> exercise ___x/wk | <input type="checkbox"/> jog ___ x/wk | <input type="checkbox"/> computer use (___ hrs per day) |
| <input type="checkbox"/> swim | <input type="checkbox"/> use elliptical | <input type="checkbox"/> watch television (___ hrs per day) |

Please add anything else you would like the doctor to know:

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ **Date** _____

(signature of parent if the patient is a minor)

Doctor's comments: _____

Pain Diagram

Please Print

Patient Name: _____ Date: _____

Please complete the following "Pain Diagram" by using the letters below to indicate on the diagram your areas of pain:

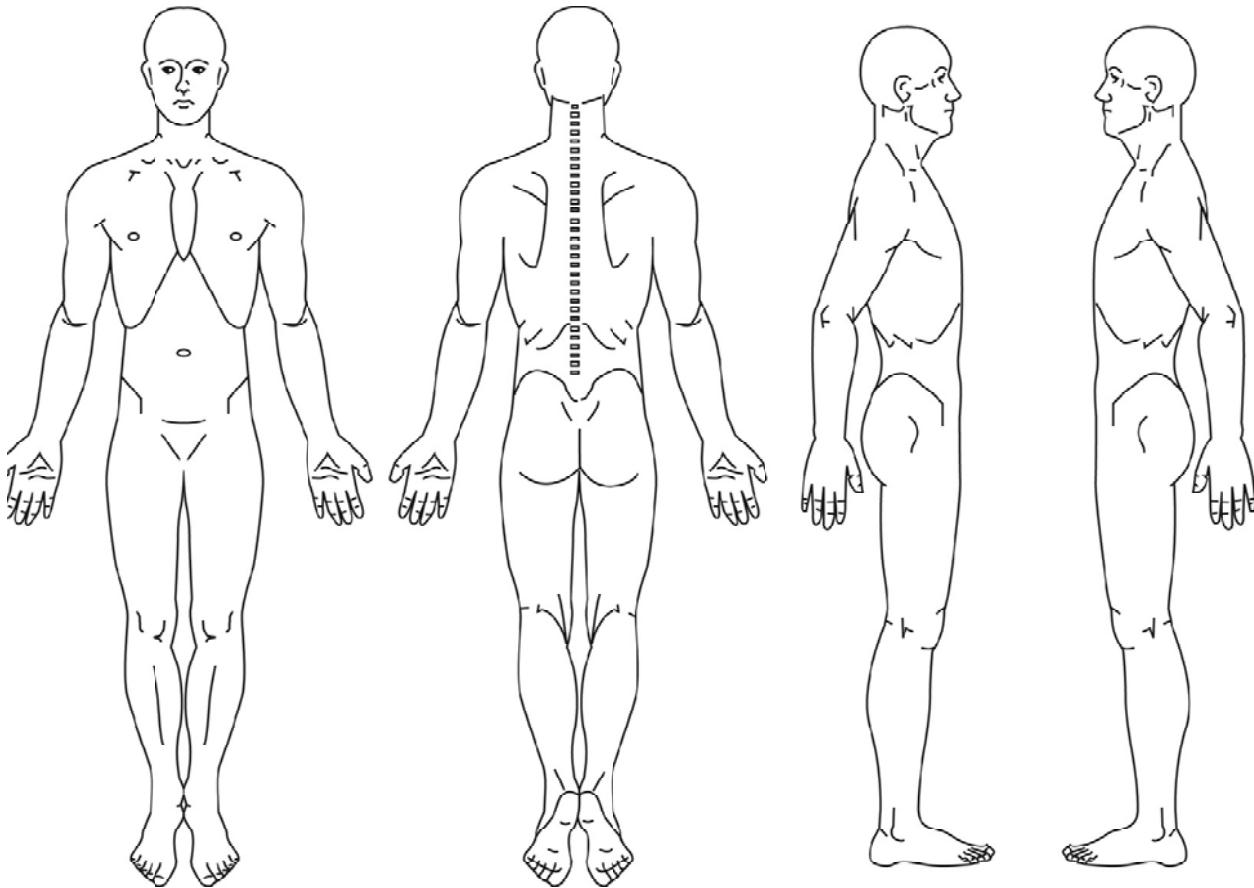
(P) Pain

(T) Tingling

(N) Numbness

(B) Burning

(S) Stiffness



Notes:

TERMS OF ACCEPTANCE
Kingen Chiropractic Wellness Center

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(name)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

(signature)

(date)

Financial Policy

It is the goal of this office to provide you the FINEST QUALITY CHIROPRACTIC CARE available. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

- I hereby acknowledge and understand that **all** charges incurred at Kingen Chiropractic Wellness Center are my responsibility.
- Kingen Chiropractic Wellness Center reserves the right to apply a service charge on all delinquent amounts more than 90 days past due. This fee will be computed at a rate of 1 1/2 % per month, 18% annum. This includes all personal injury and/or worker’s compensation cases not settled within 90 days after the case is closed.
- In the event it becomes necessary for Kingen Chiropractic Wellness Center or it’s agents to employ legal and/or collection counsel, I understand and agree I am responsible for payment of all collections and attorney’s fees, which will be added to my account/bill.
- All returned checks will be charged a twenty-five dollar service fee, plus any additional fees (i.e. bank fees, collection fees, etc...).
- There will also be a missed appointment fee of \$15.00.

I have read and understand everything described in the Financial Policy, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative

Relationship

Witness

Date Signed

**Patient Acknowledgement
For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations**

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The practice’s Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out it’s healthcare operations. The practice has further explained my right to obtain a copy of this Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The practice’s “Notice of Privacy Practices:” is also provided **in the patient bookcase** and on the practice’s web site at www.kingenchiropractic.com I may also request a copy from this office at any time via USPS, but will be personally responsible for copy fees and any postage due.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected healthcare information.

I have read and understand everything described in the Patient Acknowledgement (PHI), and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative

Relationship

Witness

Date Signed