CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____ (LAST NAME)

_____ (FIRST NAME) (MIDDLE INITIAL)

Address _____

City_____ State _____ Zip_____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation_____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

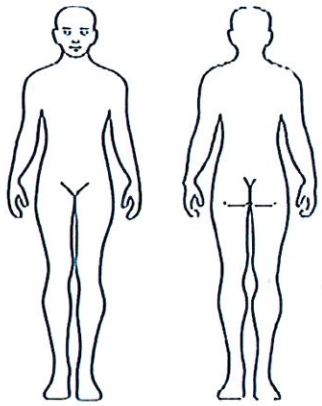
If you are already experiencing a symptom, what is it?_____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

Have you ever been to a chiropractor? Date of last visit. _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

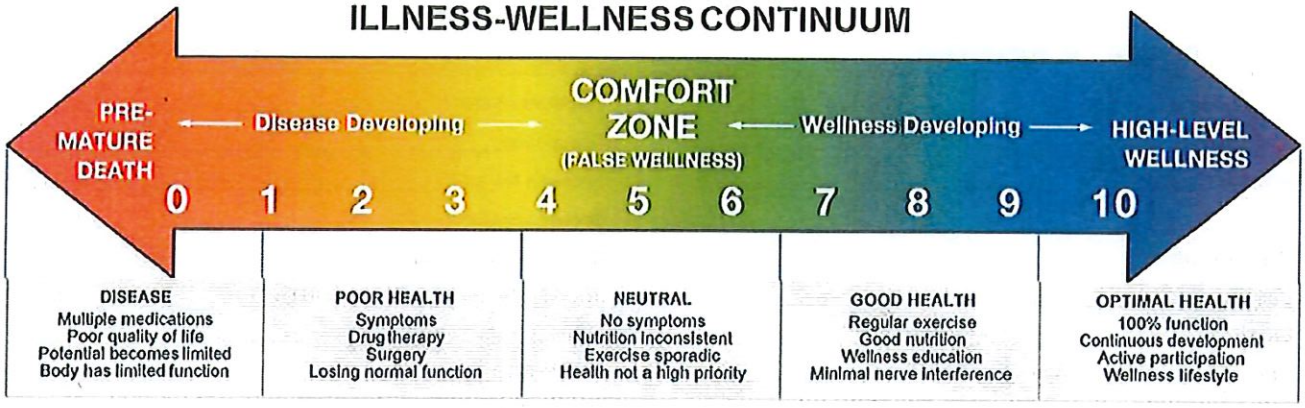
How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list) _____

MEDICATIONS (list) _____

SUPPLEMENTS (list) _____

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)

TERMS OF ACCEPTANCE

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. 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.

_____ _____
(signature) *(date)*

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.
- In the event that 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 check will be charged a $25.00 service fee, plus any additional fees (i.e. bank fees, collection fees, etc…)

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
Witness	Date Signed

Patient Acknowledgement
For us and/or disclosure of Protected Health Information (PHI)
To carry out treatment, payment and healthcare operations

I hereby state 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 its healthcare operations. The practice further explained to me 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 website at www.kingenchiropractic.com. I may 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 my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (printed)	Signature of Individual
Witness	Date signed