# 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)

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

# Patient Symptoms Questionnaire (cont.)

**Please Print**

**Patient Name: _____ Date: _____**

**General Activities** (check all that apply)

___ sleep on waterbed ___ read in bed ___ fall asleep in recliner/on couch
___ sleep on stomach ___ use two or more pillows to sleep with
___ needlepoint/knitting ___ sewing
___ lift weights/wt. mach. ___ play video games (___ hrs per day)
___ exercise ____x/wk ___ jog ___ x/wk ___ computer use (___ hrs per day)
___ swim ___ use elliptical ___ 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:*_____
_____
_____
_____
_____
_____

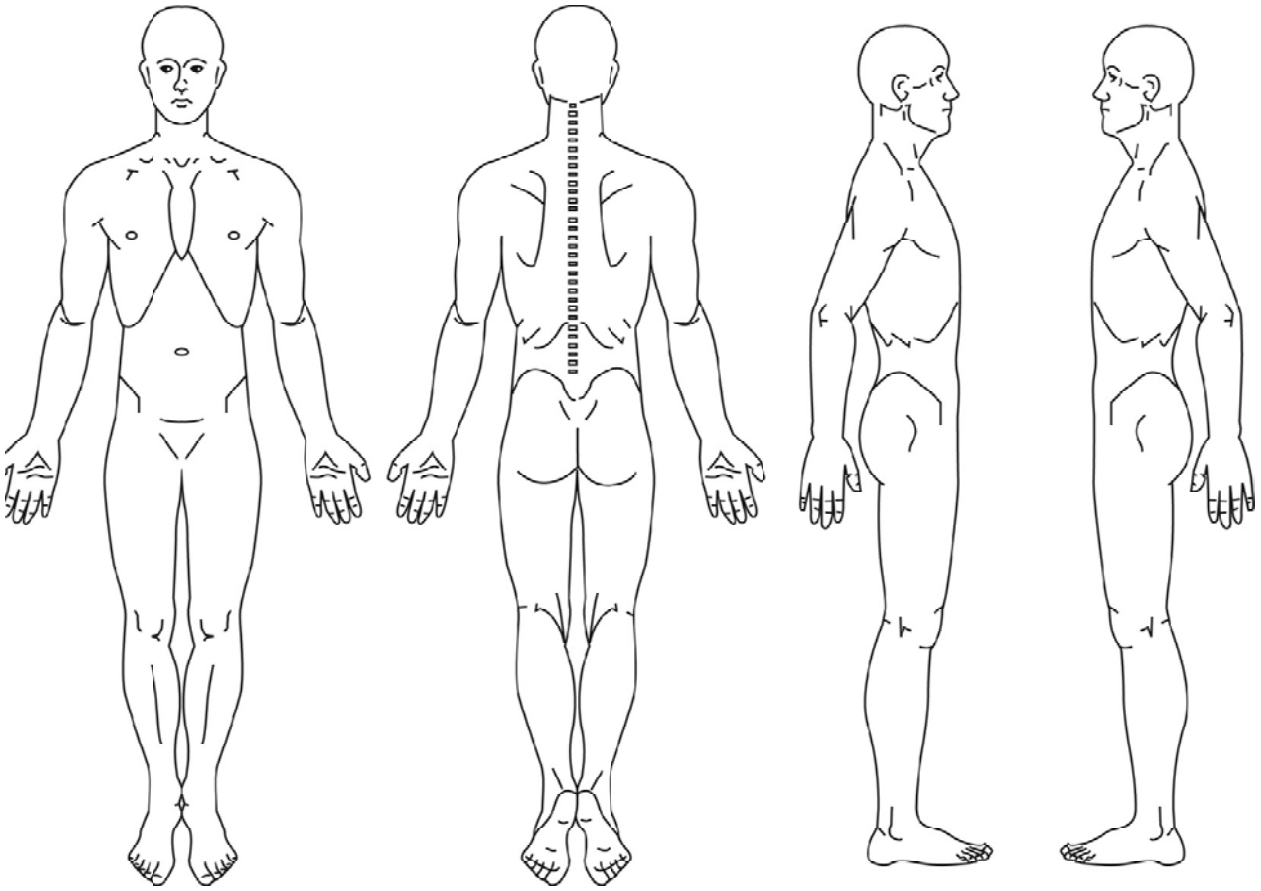
# Pain Diagram

**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