KENEMUTH Family Chiropractic

New Patient: Welcome To Our Office

Name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email address _____

Contact Preference: O Home O Cell O Work

SS# _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Is it okay to contact you at work? O No O Yes Work# _____

Marital status O Single O Married O Separated O Divorced O Widowed

Spouse's Name _____ Phone #(s) _____

Children's Names and Ages _____

_____

Do you have any pets? O No O Yes If yes, please tell us what kind(s)_____

_____

Favorite hobbies or interests _____

Emergency contact: Name_____

Relationship_____ Phone #(s)_____

What Brings You Here?

Have you ever had chiropractic care before? O No O Yes

If yes, please tell us who_____ Phone #_____

Were you pleased with your care? O No O Yes

Is this appointment related to O work O sports O auto

O other_____

When did the incident occur?_____

Attorney (if applicable)_____ Phone #_____

Are you receiving care from other health professionals? O No O Yes

If yes, please name them and their specialty_____

_____

Please list any drugs or medications you are taking_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking_____

_____

_____

Are you pregnant? O No O Yes If yes, what month?_____

If applicable, date of last menstrual period _____

Current Health

What are your pressing health concerns?_____

_____

_____

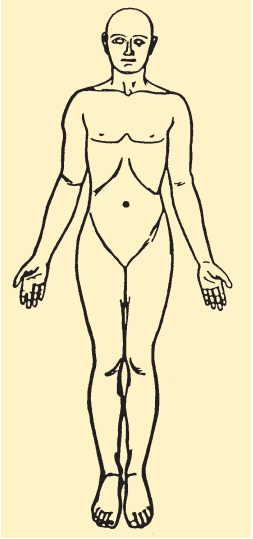
_____

_____

For how long?_____

Is it ○ getting worse ○ improving ○ intermittent ○ constant ○ can't say

Where is the problem? Please use the illustrations and lines below to explain.



○ Front _____

_____

_____

_____

_____

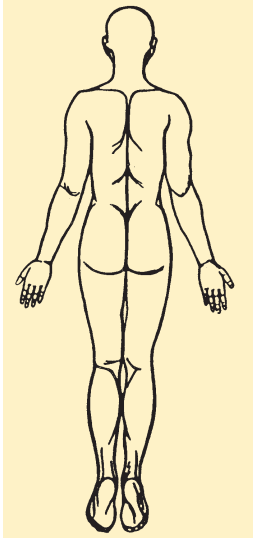
○ Back _____

_____

_____

_____

_____



Do you have ○ pain ○ numbness ○ tingling ○ aches

Is your pain ○ sharp ○ dull ○ throbbing ○ constant ○ intermittent

Are your symptoms affected by ○ sitting ○ standing ○ walking

○ bending ○ lying down ○ weather ○ other

Please explain _____

_____

Do you feel ○ cramps ○ burning ○ stiffness ○ swelling ○ other

Please explain _____

_____

Do your symptoms interfere with ○ work ○ sleep ○ day-to-day activities

○ play ○ other_____

Please explain _____

_____

_____

_____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Have you been Hospitalized in the past 5 years? O No O Yes

Do you have, or have you had, any of the following (please check ☑ all that apply)?

O pneumonia	O mumps	O influenza	O rheumatic fever	O smallpox
O pleurisy	O polio	O chickenpox	O thyroid disease	O diabetes
O epilepsy	O cancer	O depression	O whooping cough	O anemia
O eczema	O measles	O arthritis	O heart disease	O rashes
O colitis	O stroke	O allergies _____		

Have you ever been diagnosed with Hypertension? O No O Yes

If you have ever been diagnosed with another disease or condition, please describe

_____

Do you drink O coffee O tea O alcohol

Do you use O cigarettes O recreational drugs O artificial sweeteners O sugar

Have you ever suffered from (please check ☑ all that apply) Current or Past (C=Currently P=Past)

C	P		C	P		C	P	
O	O	neck pain	O	O	difficulty breathing	O	O	discolored urine
O	O	low back pain	O	O	stuffy nose	O	O	gas/bloating after meals
O	O	headache	O	O	fainting	O	O	heartburn
O	O	migraines	O	O	weight loss	O	O	irritable bowel
O	O	arm pain/tingling	O	O	poor appetite	O	O	black or bloody stools
O	O	shoulder pain	O	O	excessive appetite	O	O	constipation
O	O	hand pain/tingling	O	O	nervousness	O	O	hemorrhoids
O	O	leg pain/tingling	O	O	confusion	O	O	liver problems
O	O	jaw pain	O	O	depression	O	O	paralysis
O	O	chest pain	O	O	dental problems	O	O	numbness
O	O	lung problems	O	O	excessive thirst	O	O	fatigue
O	O	heart problems	O	O	frequent nausea	O	O	dizziness
O	O	abnormal blood pressure	O	O	prostate problem	O	O	loss of sleep
O	O	irregular heartbeat	O	O	breast pain/lump	O	O	difficulty hearing
O	O	ankle swelling	O	O	cramps	O	O	ear pain
O	O	cold extremities	O	O	painful urination	O	O	other _____
O	O	blurred vision	O	O	bladder trouble			_____
O	O	vision problems	O	O	excessive urination			_____

Past injuries can affect present health (please check ☑ all that apply)

O falls/accidents	O head injuries	O fights	O surgery
O sports injuries	O broken bones	O dislocations	O spinal tap
O knocked unconscious	O use(d) a cane or walker	O traction	
O extensive dental work	O dental applications	O other _____	

_____

If yes to any of the above, please describe _____

_____

Family Health

Do you have any family history of conditions that may pertain to your condition?_____

Are there other health concerns or anything else you'd like us to know about you?

O no O yes If yes, please tell us

The above is accurate to the best of my knowledge.

(Signature) (Date)

I, parent/guardian, give permission for minor's care.

(Signature) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Patient Signature

_____

Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

List below the names and relationship of people to whom you authorize the practice to release PHI.

_____ _____

_____ _____

_____ _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure. As with all types of healthcare interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving healthcare or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractic with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

Financial Agreement and Policy

Most insurance policies cover chiropractic/medical care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage of chiropractic/medical care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our very best to verify your insurance coverage. If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

As a courtesy to our patients upon request, this office will submit to your insurance company for payment for services rendered. When we submit the claims to the insurance carrier we "accept assignment" (payment will come to our office directly). This means that you assign benefits to our office and the insurance company should send an explanation of benefits (EOB) and inform you what they have paid to this office.

Our office is pleased to accept your insurance assignment when the responsible party verifies your exact coverage. We will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

Often, the insurance company will overlook our annotation that we accept assignment and will send that check directly to the patient. If this occurs, kindly bring the check and the explanation of benefits into our office and endorse it over to us for payment so your account may be properly credited. Since by taking your insurance on assignment we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it. If you discontinue care without the doctor's authorization, the balance of your account is due and payable in full within 30 days, even if your insurance has been filed. (If the insurance does pay, it will be refunded if you have a zero balance.) Your insurance company is required by law to respond to a claim within 30 days of receipt. If your insurance company has not paid within 60 days you must pay the balance due and be reimbursed by your insurance company when and if it pays. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. However, if necessary, we will assist you to the best of our ability.

If you wish to submit to your own insurance and pay in full each visit, we will provide you with statements to facilitate your insurance submissions.

AGREEMENT

OPTION 1: I hereby agree to have the office accept assignment of benefits and to pay according to the terms noted above. I ask that the office submit my charges directly to my insurance carrier and I understand that I am personally responsible for whatever portion my insurance does not cover. I agree to pay the copayment amount (amount assumed not likely to be paid by insurance) at each visit.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

OPTION 2: I wish to waive having my insurance assigned to Dr. Michael Kenemuth and I hereby agree to pay in full at the time of service rendered.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE