Kline Chiropractic

Name____ Date____________________

Address____________________________ City_________________ State_____ Zip________

Home Ph.___________________ Cell Ph._________________Work Ph.________________

DOB_________________ Marital Status: S M D W Sex: M / F Occupation_________________

Employer__________________________ Employer Address__________________________

How did you hear about our office?____

Email Address____

Main Complaint

1. What is your major symptom?____
2. What does this prevent you from doing/enjoying?____
3. What is your treatment goal?____
4. If this is a recurrence, when did the problem first appear?___________________________________
5. How did originally occur?____
6. Has it become worse recently? Yes____ No____ Same____ Gradually Worse____. If yes, when and how?
   ____
7. How frequent is this condition? Constant____ Daily____ Intermittent____ Night Only____
8. How long does it last? All Day____ Few Hours____ Minutes____
9. How many days have you lost from work due to these symptoms?_____________________________
10. Are there any other conditions or symptoms that may be related to your major symptoms? Yes____ No____. If yes, describe:____
11. Are there other related health problems? Yes____ No____. If yes, describe:_______________________
    Describe Pain: Sharp___ Dull ___ Numbness ___ Tingling___ Aching___ Burning____ Stabbing___ Other___
12. Is there anything you can do to relieve the problem? Yes___ No___. If yes, describe:__________________
    ____
    If no, what have you tried that has not helped?____
13. What makes the problem worse? Standing____ Sitting____ Lying____ Bending____ Lifting____ Twisting____
    Other____
14. Have you had any broken bones? Yes___ No___. If yes, please list with dates:_______________________
    ____
15. Please list any major accidents that were not mentioned above:_________________________________
    ____
16. History of disease, major illnesses, or injuries?____
17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes___ No___ Uncertain____ Date of last menstrual cycle:_______________ Do you have PMS? Yes____ No____

Medical History

Past Chiropractic care/ Doctor's name____

Medications____

Surgeries (include dates):____

____

Do you have any difficulty with the following?

___Headaches	___Fainting	___High Blood Pressure	___Bladder trouble
___Shooting head pains	___Loss of Balance	___Low Blood Pressure	___Menstrual cramps
___Sinus trouble	___Ringing in ears	___Anemia	___Menstrual Irregularity
___Loss of smell	___Dizziness	___Rheumatic Fever	___Diabetes
___Hayfever	___Light sensitivity	___Nervous stomach	___Cancer
___Asthma/allergies	___Neck muscle spasms	___Stomach trouble	___Sleeping problems
___Loss of taste	___Grating in neck	___Ulcers	___Painful joints
___Tightness in throat	___Shoulder tightness	___Nerves and/or nervousness	___Swollen joints
___Inflammation of throat	___Neuritis	___Inner tension	___Arthritis
___Thyroid trouble	___Tingling in hands	___Irritability	___Slipped disc
___Face flushed	___Cold hands	___Cold sweats	___Pinched nerve in back
___Face twitching	___Chest pains	___Liver trouble	___Tingling in feet
___Loss of Memory	___Shortness of breath	___Gallbladder trouble	___Swollen ankles
___Fatigue	___Heart attacks	___Indigestion	___Cold feet
___Depression	___Heart pain	___Intestinal gas	___Leg/foot pain
___Head feels too heavy	___Heart palpitations	___Constipation	___Kidney trouble
___Weight gain	___Weight loss		

Family Medical History

___Allergies	___Cancer	___Diabetes	___Osteoporosis	___Mental Illness
___Asthma	___Arthritis	___Stomach Disorder	___Alzheimer's	___Stroke
___Heart Disease	___Kidney Disease	___Alcoholism	___Obesity	

(Please place an "F" for father or father's side or "M" for mother or mother's side of the family in front of anything marked in the section above.)

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are the major causes? ___Work ___Family ___Finances ___Relationships ___Emotions ___Other:___________

I eat the following: ___Sweets ___Sodas/Pop ___Ice cream ___Fried foods
___Cereals ___Legumes ___Fruits ___Vegetables

This applies to me: ___Diets frequently ___Skips meals ___Dines-out regularly

Eat (0 1 2 3 4 5 6 more) meals per day

When do you eat? ___Morning ___Noon ___Night ___Constantly snacking

Do you:

-Use Tobacco? YES / NO If yes, how much daily?____

If no, did you ever? YES / NO If yes, how much?___________ Quit date:________

-Drink Coffee? YES / NO If yes, how much daily? ____

-Drink Tea? YES / NO If yes, how much daily?____

-Eat Chocolate? YES / NO If yes, how much daily?____

-Drink Alcohol? YES / NO If yes, how often and how much? _________Daily ________Weekly _____Socially
_________Rarely

If no, did you ever & how much? __________________ Quit date: ______________

-Have any food restrictions? ___YES ___NO If yes, please list:____

Exercise: ______Daily _______Weekly _______Rarely _______Never

Patient Signature (or parent/legal guardian if <18)____

Date___________________________

Kline Chiropractic

HIPAA Information & Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A Notice of Privacy Practices should be available to you in the office. The office provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

* Protected health information (PHI) may be disclosed or used for treatment, payment, or health care operations.
* Authorization is required for certain disclosures of your PHI.
* You have the right to opt out of fundraising communications.
* You have the right to restrict disclosures of your PHI under certain circumstances.
* You have the right to be notified of a breach of unsecured PHI.

By signing below you understand and agree that:

* The practice has a Notice of Privacy Practices that you have the opportunity to review.
* The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
* You may revoke this consent in writing at any time and all future disclosures will cease.
* The practice may condition treatment upon the execution of this consent.

Patient Signature (or parent/legal guardian if <18)_______________________________________

Date______________________

Financial Policy

This is a consent form used to ensure the understanding that this is an agreement between you and your insurer. This is not an agreement between your insurer and this facility. Chiropractic insurance benefits have a wide variety of coverage plans. Kline Chiropractic will call the insurance provider to verify your benefits, although this is NOT a guarantee of payment from the insurer. With that in mind, please select a payment option below:

1. ________ I would like Kline Chiropractic to bill my insurance. I understand I am responsible for all costs of treatment that is not covered by my insurer.

2. ________ I do not have insurance, and I will be responsible for all costs that are inquired. I will keep my account current by paying for services at the time they are rendered.

3. ________ I have insurance, but Kline Chiropractic is OUT OF NETWORK. If claims need to be filed with my insurance company, I will be personally responsible for filing claims those claims. I will keep my account current by paying for services at the time they are rendered.

4. ________ I understand this is Auto Accident related and cannot be billed to my medical insurance. I will keep my account current by paying for services at the time they are rendered. I further understand that I am required to pay a records fee of $20 today. This fee covers the costs associated with sending bills and medical records to the auto insurance company.

Kline Chiropractic requires a credit card to be kept on file:

1. A missed appointment/cancellation fee for any services cancelled without 24 hour notice of your scheduled appointment. If you miss your appointment without calling our office with proper notification or if you are more than 15 minutes late to your appointment, you will be charged a missed appointment fee for your missed appointment time.

   Thank you for being aware that Kline Chiropractic provides care for numerous individuals and missed or cancelled appointments take away time providing care for others who may be in a lot of pain. We and that other patients appreciate your understanding and compliance with this policy.

2. If your account balance is more than 30 days overdue, we will give notice of the balance and by 60 days the card on file will be used to return your account to good standing.

_____ Initial here acknowledging you agree to the policy above.

I understand that all chiropractic services rendered to me and charged to me are my personal responsibility. I understand and agree to the conditions of this policy.

Patient Signature (or parent/legal guardian if <18)____

Date______________________