Kline Chiropractic

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Ph._____ Cell Ph._____Work Ph._____

DOB_____ Gender/Prounouns_____

Occupation_____ Employer_____

How did you hear about our office?_____

Email Address for appointment reminders: _____

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
___Shooting head pains
___Sinus trouble
___Loss of smell
___Hayfever
___Asthma/allergies
___Loss of taste
___Tightness in throat
___Inflammation of throat
___Thyroid trouble
___Face flushed
___Face twitching
___Loss of Memory
___Fatigue
___Depression
___Head feels too heavy
___Weight gain

___Fainting
___Loss of Balance
___Ringing in ears
___Dizziness
___Light sensitivity
___Neck muscle spasms
___Grating in neck
___Shoulder tightness
___Neuritis
___Tingling in hands
___Cold hands
___Chest pains
___Shortness of breath
___Heart attacks
___Heart pain
___Heart palpitations
___Weight loss

___High Blood Pressure
___Low Blood Pressure
___Anemia
___Rheumatic Fever
___Nervous stomach
___Stomach trouble
___Ulcers
___Nerves and/or nervousness
___Inner tension
___Irritability
___Cold sweats
___Liver trouble
___Gallbladder trouble
___Indigestion
___Intestinal gas
___Constipation

___Bladder trouble
___Menstrual cramps
___Menstrual Irregularity
___Diabetes
___Cancer
___Sleeping problems
___Painful joints
___Swollen joints
___Arthritis
___Slipped disc
___Pinched nerve in back
___Tingling in feet
___Swollen ankles
___Cold feet
___Leg/foot pain
___Kidney trouble

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 not covered by my insurer.

   Insurance Primary: Self/Other If other Name:_____DOB:_____

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.

Appointment Policy

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.

_____ 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_____