## Patient Information

Name_____ Date _____

Address_____ City_____

State_____ Zip _____ Cell Phone_____ Home Phone_____

Email_____ Date of Birth_____ Age_____

Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____ Employer_____

Do you have insurance? ❑ Yes ❑ No Insurance name:_____

Primary insured?❑ Yes ❑ No If no, primary insured name and relationship to self: _____

What is the best way to contact you? *(check one)* ❑ Email ❑ Cell Phone ❑ Home Phone

Who can we thank for referring you? _____

Emergency Contact:_____ Phone #:_____

Race _____ Ethnicity _____Preferred Language _____

**FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past.**

****Please state (P) for Patient or (F) for family****

| | | | | | |
|---|---|---|---|---|---|
| ❑ Alcoholism | (P or F) | ❑ High Blood Pressure | (P or F) | ❑ Stroke | (P or F) |
| ❑ Anemia | (P or F) | ❑ Kidney Disease | (P or F) | ❑ Suicide Attempt | (P or F) |
| ❑ Asthma | (P or F) | ❑ Liver Disease | (P or F) | ❑ Thyroid Disease | (P or F) |
| ❑ Celiac disease | (P or F) | ❑ Hashimoto's disease | (P or F) | ❑ Trouble Sleeping | (P) |
| ❑ Cancer/Tumor | (P or F) | ❑ Hepatitis | (P or F) | ❑ Tuberculosis, TB | (P or F) |
| ❑Crohn's disease | (P or F) | ❑ High Cholesterol | (P or F) | ❑ Ulcers | (P or F) |
| ❑ Diabetes | (P or F) | ❑ Lung Disease | (P or F) | ❑ Venereal Disease | (P or F) |
| ❑ Drug Abuse | (P or F) | ❑ Mental Illness | (P or F) | ❑ HIV or Other Immune Disease | (P or F) |
| ❑ Depression | (P or F) | ❑Osteoarthritis | (P or F) | ❑Fibromyalgia | (P or F) |
| ❑ Epilepsy/Seizures | (P or F) | ❑ Osteoporosis | (P or F) | ❑ Other _____ | (P or F) |
| ❑ Glaucoma | (P or F) | ❑ Phlebitis | (P or F) | | |
| ❑ Heart Disease | (P or F) | ❑ Rheumatic Arthritis | (P or F) | | |

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑Never been a smoker

*If yes, how often do you smoke:* ❑ Current every day smoker ❑ Current sometimes smoker

Cigarettes a day:_____ Packs a day:_____ Alcohol: Yes/No If yes, drinks per week: _____

Exercise frequency _____ Recreational drug use? Yes / No

Current medications, including dosage if known: If there are no current medications, check here: ❑

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

PATIENT SIGNATURE: _____ DATE: _____ Dr. Initial _____

**PATIENT NAME**_____

**Have you ever had allergy testing done?** ❑ Yes ❑ No **If yes, when?**_____

**List any known allergies you have had to any medications, foods or environment:**

**If no allergies are known, check here:**❑

**1)** _____ **3)** _____

**2)** _____ **4)** _____

**5)** _____ **6)** _____

**Has any doctor diagnosed you with Hypertension (high blood pressure) presently?** ❑ Yes❑ No

If yes, describe:_____

**Has any doctor diagnosed you with Diabetes presently?**❑ Yes ❑ No If yes, what kind? ❑Type I ❑ Type II

***If yes to Diabetes, was your blood lab-work test for hemoglobin A1C> 9.0%?*** ❑Yes ❑No ❑Not Sure

***If yes, other comments regarding Diabetes:***_____

**Primary Care Physician** _____**Address**_____ **Phone**_____

**When was your last Physical examination?** _____

**When did you last have blood work?** ❑ Within a Year ❑ Over a Year ❑ Not Sure

**Have ever been referred to a specialist?** ❑ Yes ❑No If yes, describe:_____

**Have you ever had chiropractic care?** ❑ Yes ❑ No **If** Yes, how long ago?_____

**Has any of your family received chiropractic care?** ❑ Yes ❑ No

**When was the last time you were involved in an accident of any kind, please describe?** _____

_____

_____

**1. Chief Complaint:**_____

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

When did it start?_____ Gradual / Sudden

Circle the percentage of day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

**2. Chief Complaint :**_____

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

When did it start?_____ Gradual / Sudden

Circle the percentage of day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

**3. Chief Complaint:**_____

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

When did It start?_____ Gradual / Sudden

Circle the percentage of day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

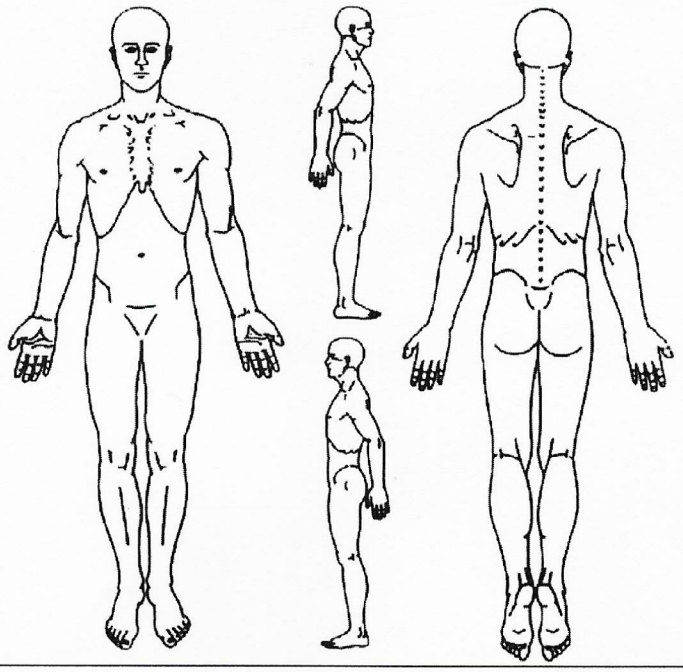
What job activities are you unable to do? _____

When do you feel it most? AM PM When present, how long does the complaint last? _____

What makes it feel better? _____What makes it feel worse?_____

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain

**Below, please show where you are experiencing <u>all</u> of your current symptoms:**



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

| | | |
|---|---|---|
| Walking | Y | N |
| Computer work | Y | N |
| Standing | Y | N |
| Running | Y | N |
| Sleeping | Y | N |
| Driving | Y | N |
| Personal Grooming | Y | N |
| Sitting | Y | N |
| Kneeling | Y | N |
| Exercising | Y | N |
| Bending | Y | N |
| Lifting Objects | Y | N |
| Lifting Children | Y | N |
| Housework | Y | N |

1. Have you ever had tests for your present condition? MRI X-ray CT Other_____
2. Do you have a pacemaker? Yes No Do you have any artificial joints or metal in other regions?_____
3. Have you ever lost work due to your condition(s)? Yes No If Yes, dates?_____
4. Are you pregnant? Yes No Number of pregnancies? _____ Number of miscarriages? _____
5. What was the first day of your last menstrual cycle? _____

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low Medium High
0 1 2 3 4 5 6 7 8 9 10

What is YOUR goal for treatment? _____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge:

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Dr. Initials _____

**STAFF USE ONLY** **Height:** _____inch **Weight:** _____ pounds **BP**_____/_____ P _____

# Health Care Information Authorization

At times our office may need to contact you with appointment information about treatment or other health related information. By signing below, you are giving Kai Health & Wellness and any doctors/employees of Kai Health & Wellness authorization to contact you by the following:

(Please draw a single line through any methods you REFUSE and initial)

- **I may be contacted by** home, work, or cell phone.
- **Messages may be left** on my home, work, or cell voicemail OR to any individuals answering my phone at home or work.
- **Also I may be contact by postal mail or e-mail** to receive personalized cards (birthday/holiday/special events), office newsletter, special office announcements or appointment reminders. With my permission, my name and or photograph may be used for office events, bulletin board, newsletters or patient testimonials

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that any person or entity has already acted in reliance of your authorization or if authorization was obtained as a condition of obtaining insurance coverage. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Kai Health & Wellness. The written notice must contain the following information:

- Your name, social security number and date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- Your signature as well as the date of your request

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Kai Health & Wellness for its own use/disclosure of protected health information (minimum necessary standards apply). You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Kai Health & Wellness will not refuse to provide treatment. You have the right to inspect or copy the protected health information to be used/disclosed.

** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU **

**PERSONAL REPRESENTATIVES** (family members, attorneys, etc.) I hereby authorize Kai Health & Wellness and it's employees permission to discuss, send and/or receive medical information to/with the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

In certain cases we like to co-manage your case with your primary care physician. Do you authorize us to send notes or records to them? YES NO

If Yes, please provide us the following information: Primary Care Doctor _____ Office Phone _____

**My signature below indicates that I have read and agree to the above authorization and I acknowledge that I have read a copy of Kai Health & Wellness Notice of Privacy Practices. I understand that a copy of Notice of Privacy Practices is available to me at any time.**

_____ _____

Patient Name Printed Personal Representative Name Printed

_____ _____

Patient Signature Signature of Personal Representative

_____ _____

Date Description of Personal Representative Authority to act for Patient

# Kai Health & Wellness
# Patient Responsibility, Consent & Disclosures

**Please initial next to each item below:**

**Financial Policy**

_____ I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Patients are responsible for the payments of co-pays, co-insurance, deductibles, and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for explanation of any services not covered. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

_____I agree that any insurance checks sent directly to me or insurance policy holder for services rendered with any doctor at Kai Health & Wellness will be brought into our clinic.

_____ I the undersigned, assign directly to Kai Health & Wellness all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of healthcare information and records to all insurance companies and to other treating providers whom I am seeking care from.

**Cancellation of Massage Appointments**

_____I understand that there is a 24 hour cancellation policy for massages.

_____ I understand that I, not the insurance company, personal injury case, or workers compensation case, will be charged the value of the massage if I do not cancel 24 hours prior to the scheduled massage.

**Consent to care**

_____As a patient with Kai Health & Wellness you have the right to know the types of treatment we could possibly use and any complication/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however, unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. I am responsible for informing my doctors about any conditions, diseases, illnesses, etc. I agree to settle any claim or dispute against/with the clinic or personnel, where related to the prescribed care or otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. I hereby allow treatment to be rendered to myself by all Kai Health & Wellness Center physicians or staff.

**********

I have read, understand, and agree to the provisions of this Patient Responsibility, Consent and Disclosure form:
Please sign/date below:

Printed Patient Name: _____ Date: _____

Signature of Patient: _____ Witness:_____