Kent Chiropractic Clinic
Patient Information

Patient Information

Legal First Name | Legal Last Name | M.I. | Preferred First Name

Permanent Address | Apt # | City | State | Zip

Home Phone# | Cell Phone# | Work Phone# | Gender | Birth Date

Marital Status | Email Address | Today's Date

Emergency Contact Information

Contact Name | Phone # | Relationship to Patient

Employment Information

Occupation | Employer's Name

Medical Insurance Information (IF OTHER THAN PATIENT)

Policy Holder's Name | Policy Holder's Relationship to Patient | Policy Holder's Date of Birth

Policy Holder's Address | City | State | Zip

Kent Chiropractic Clinic
Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Kent Chiropractic.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition any remaining balance on your account will be billed to you.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- Co-payments are due before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Kent Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Kent Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me and not paid for by insurance are charged directly to me and that I am personally responsible for payment. *If payment is not received in 30 days after being billed by this office, an 8% interest fee (compounded annually) will be added to your account.*

_____ _____

Responsible Party's Signature Date

Kent Chiropractic Clinic
Consent for Treatment

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedure provided by Kent Chiropractic Clinic. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of treatments or examinations by Kent Chiropractic Clinic.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and therapies consistent with Kent Chiropractic Clinic's Notice of Privacy Practices.
3. I authorize payment of medical benefits to Kent Chiropractic Clinic for services rendered.

_____ _____

Patient or Authorized Person's Signature Date

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice and Release of Information. _____
Initial

Kent Chiropractic Clinic
Personal Injury – Patient Info Form

Name:_____ File #:_____ Date:_____

Date of Accident: _____ Time: _____AM/PM

Driver of Car: _____ Where were you seated:_____

Car Owner:_____ Year & Model of Auto: _____

What was the approximate damage done to the car:_____

Visibility at time of accident: [ ] poor [ ] fair [ ] good [ ] other:_____

Road conditions at time of accident: [ ] icy [ ] rainy and wet [ ] clear [ ] dark [ ] other:_____

Describe:_____

_____

Where was the car struck: [ ] right [ ] left [ ] rear [ ] front [ ] side [ ] other :_____

Type of accident: [ ] head-on collision [ ] broad-side collision

[ ] rear-end collision [ ] front impact, rear-ended car in front

[ ] non-collision: _____

Describe in your own words what happened to you upon impact: _____

_____

Did you see the accident coming? Yes/No

Did you brace yourself for impact? Yes/No

Were you wearing a seat belt with a shoulder harness? Yes/No

Did the car have headrests? Yes/No

If yes, what was the position of the headrest compared to your head before the accident?

[ ] top of headrest even with bottom of head

[ ] top of headrest even with top of head

[ ] top of headrest even with middle of neck

Was the car you were in braking at the time of the accident? Yes/No

Was the car you were in moving at the time of the accident? Yes/No

If yes, how fast would you estimate you were going? _____mph

How fast was the other car involved in the accident travelling? _____mph

Head/Body position at time of impact:

[ ] head turned left/right [ ] body straight in sitting position

[ ] head turned and looking back [ ] body rotated left/right

[ ] head straight forward [ ] other: _____

At the time of the accident, recall what parts of you head or body hit what parts on the inside of the car: _____

_____

As a result of the accident you were:

[ ] rendered unconscious

[ ] dazed, circumstances vague

[ ] other _____

Could you move all parts of your body? Yes/No

If no, what body parts and why? _____

Were you able to get out of the car and walk unaided? Yes/No

If no, why not? _____

Did you get bleeding cuts or bruises? Yes/No

If yes, what bleeding cuts did you get from the accident? _____

If yes, what bruises did you get from the accident? _____

Please describe how you felt. Please be specific.

Immediately after the accident: _____

Later that day: _____ Night: _____

The following day: _____ Days: _____

Check the symptoms apparent since the accident:

[ ] Headache	[ ] Loss of smell	[ ] Numbness in fingers
[ ] Neck pain/Stiffness	[ ] Loss of taste	[ ] Cold hands
[ ] Mid back pain	[ ] Loss of memory	[ ] Cold Feet
[ ] Low back pain	[ ] Fatigue	[ ] Diarrhea
[ ] Eyes sensitive to light	[ ] Tension	[ ] Constipation
[ ] Pain behind eyes	[ ]Shortness of breath	[ ] Chest pain
[ ] Dizziness	[ ] Irritability	[ ]Nervousness
[ ] Fainting	[ ] Depression	[ ] Cold sweats
[ ]Ringing/buzzing in ears	[ ] Sleeping problems	[ ] Anxiousness
[ ]Loss of Balance	[ ] Numbness in toes	[ ] Other: _____

Occupation: _____ Employer: _____

Have you missed time from work due to this accident? Yes/No

If yes, Full time off work: _____ to _____ : _____ to _____

Part time off work: _____ to _____ : _____ to _____

[ ] Been unable to work since accident.

Did you go to seek medical help immediately/soon after the accident? Yes/No

If yes, how did you get there? [ ] someone drove you [ ] ambulance

[ ] drove myself [ ] police

[ ] other: _____

What benefits did you receive from the treatment? _____

_____

Date of last treatment: _____

Doctor 2/Hospital/Clinic seen: _____ Date: _____

Were you examined? Yes/No Were x-rays taken? Yes/No

Were you given treatment? Yes/No

If yes, what treatment was given to you? [ ] bed rest [ ] brace [ ] physiotherapy

[ ] adjustments [ ] drugs [ ] other _____

What benefits did you receive from the treatment? _____

_____

Date of last treatment: _____

Doctor 3/Hospital/Clinic seen: _____ Date: _____

Were you examined? Yes/No Were x-rays taken? Yes/No

Were you given treatment? Yes/No

If yes, what treatment was given to you? [ ] bed rest [ ] brace [ ] physiotherapy

[ ] adjustments [ ] drugs [ ] other _____

What benefits did you receive from the treatment? _____

_____

Date of last treatment: _____

Did you have any physical complaints **JUST BEFORE** the accident? Yes/No

If yes, please describe in detail: _____

_____

(briefly include all falls, injuries, accidents, operations, etc)

Do you notice any activities of your daily routine at HOME that are different **now than from before** the accident? Yes/No

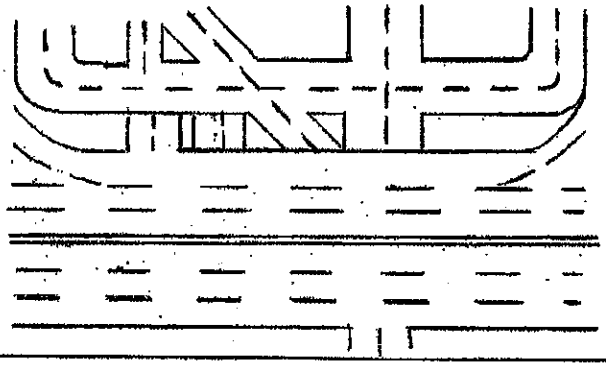
If yes, list them as:

Those that you are unable to do: _____

Those that are painful to do: _____

Those that are difficult to do: _____

Indicate on this diagram how the accident happened.



Do you have an attorney on this case? Yes/No

If yes, who? Name _____

Address _____ City _____ Zip _____

Patient Signature _____ Date _____

Automobile Accident – Insurance Data

Patient's Insurance Information

Company Name _____ Phone _____ Policy # _____

PO Box/Street Address _____ Adjuster's Name _____

City _____ State _____ Zip _____

Insured's Insurance Information

Insured's Name if other than patient _____ Phone _____

Company Name _____ Phone _____ Policy # _____

PO Box/Street Address _____ Adjuster's Name _____

City _____ State _____ Zip _____

Patient Health Questionnaire

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 4/18/08

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

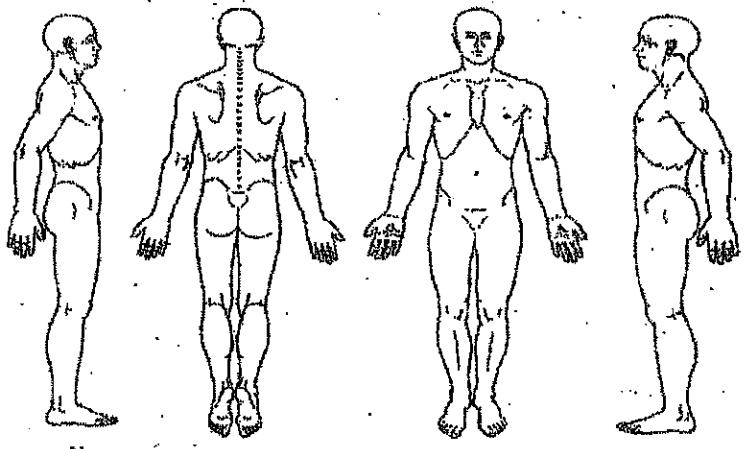
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

None ... Unbearable

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ No complaints ① ② Mild, forgotten with activity ③ ④ Moderate, interferes with activity ⑤ ⑥ Limiting, prevents full activity ⑦ ⑧ Intense, preoccupied with seeking relief ⑨ ⑩ Severe, no activity possible

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

11. What is your occupation? _____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time, ④ Unemployed ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

① Reduce symptoms ③ Explanation of condition/treatment ⑤ How to prevent this from occurring again
② Resume/increase activity ④ Learn how to take care of this on my own ⑥

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuous

What is your height and weight? Height ☐☐☐ (Feet / Inches) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	**Females Only**		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	**Other Health Problems/Issues**		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____