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
Worker's Compensation

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.

- If you are a worker's compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments by the worker's compensation carrier as per contracted rates based on the mandated MN state fee schedule.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

- 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.
- I authorize payment of medical benefits to Kent Chiropractic Clinic for services rendered.

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 that are not covered by my 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

*I have received/been offered a copy of the Notice of Privacy Practice, Financial Policy Notice and Release of Information.*________
initial

Patient 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 hereby authorize Kent Chiropractic Clinic to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

______________________________ ______________________

Patient or Authorized Person's Signature Date

Patient Health Questionnaire

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name ______________________ *Date* ______________________

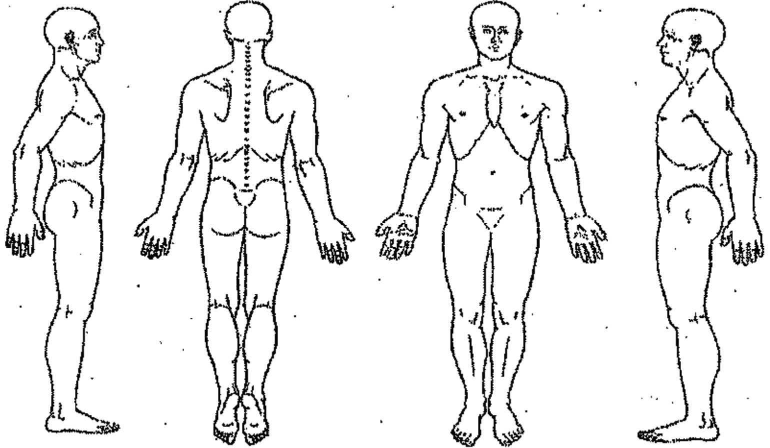
1. When did your symptoms start: ______________________ ***Describe your symptoms and how they began:***

____

____

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	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*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 ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed?
① Xrays *date:* __________ ② MRI *date:* __________ ③ CT Scan *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 ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

11. What is your occupation? ______________________
① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

***12. What do you hope to get from your visit/treatment** (select all that apply):*
① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
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? ① None ② Light ③ Moderate ④ Strenuous

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	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS
Females Only		
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	
Other Health Problems/Issues		
○	○	
○	○	
○	○	

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** ____________

Kent Chiropractic Clinic
Worker's Compensation – Patient Data Form

Name:____________________ File #:____________________ Date:____________________

Worker's Legal Name:____________________ Time of Injury: ____________________AM/PM

Worker's Address:____________________ Date of Injury:____________________

City:____________________ State: __________ Zip Code:__________ Home Phone:____________________

Date of Birth:____________________ Male______ Female ______ Cell Phone:____________________

Date Last Worked: ____________________ Social Security Number:____________________

Employer's Business Name (at time of accident):____________________

Employer's Phone:____________________ Employer's Address:____________________

City:____________________ State:__________ Zip Code:__________

Occupation:____________________ Describe your job:____________________

What were you doing at the time you were injured? How did the accident/injury happen (lifting, bending, walking, carrying, standing, etc)? ____________________

____

____

<u>WHEN</u> did the pain begin? <u>WHERE</u> did you first feel it? Was the pain intense at first, or did you feel pain that gradually worsened? <u>Please be specific.</u> ____________________

____

____

Describe the physical conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards created by other employees such as housekeepers.) ____________________

____

____

Were you hospitalized as a result of this accident? Yes/No
If yes, where? ____________________

Doctor 1. Name: ____________________ Date of first visit:____________________
Were you examined? Yes/No Were X-rays taken? Yes/No
Did you receive treatment? Yes/No
If yes, what kind of treatment did you receive?____________________
What benefits did you receive from the treatment?____________________
____________________Date of last treatment:____________________

Doctor 2. Name:____________________ Date of first visit:____________________
Were you examined? Yes/No Were X-rays taken? Yes/No
Did you receive treatment? Yes/No
If yes, what kind of treatment did you receive?____________________
What benefits did you receive from the treatment?____________________
____________________Date of last treatment:____________________

Doctor 3. Name:______________________________ Date of first visit:______________
Were you examined? Yes/No Were X-rays taken? Yes/No
Did you receive treatment? Yes/No
If yes, what kind of treatment did you receive?______________________________
What benefits did you receive from the treatment?______________________________
______________________________Date of last treatment:______________

What date did you report this injury? ______________ To whom did you report it?______________

What is their position/title? ______________________________

Was there a witness to your injury? ______________________________

If yes, what is their name(s) and position/title? ______________________________

____

Have you ever had any <u>PRIOR</u> Injuries, accidents, diseases, or treatment to the area of your body now affected? Yes/No

If yes, answer with specific dates and treatments (from when to when). ______________________________

____

____

If yes, state what part of your body was PREVIOUSLY injured:______________________________

Date hurt: ______________ Describe the injury: ______________________________

Were you treated? Yes/No

If yes, who treated you?______________________________

What date did treatment begin? ______________ And end? ______________

When was the last time you felt pain or problems from that injury? ______________________________

Have you lost any time at work as a result of this injury? Yes/No

If yes, give dates: ______________________________

If you are currently on <u>disability (time loss)</u>, do you want to go back to work doing your <u>regular</u> duties? Yes/No

If no, state why: ______________________________

Have you gone back to work? Yes/No

If yes, when: ______________ What status of work? Modified ________ Regular ________

Please list the restrictions on which you have been placed: ______________________________

____

If you have gone back to work, please list the activities that are:

Painful ______________________________

Difficult ______________________________

Are there any reasons/problems you have with a fellow employee, supervisor, or management that needs to be discussed? Yes/No

If yes, please discuss: ______________________________

On a scale of 1-5, with 1 being "I'm pain free and can function quite well", and 5 being "I'm in pain all the time and cannot function at all", where would you rate yourself? 1 2 3 4 5 (circle one) Please explain why: ______________________

____

____

Do you find any activities that you perform at home painful or difficult? Yes/No

If yes, those home activities that are:

Painful (be specific): ______________________

Difficult (be specific): ______________________

Are you performing exercises at home at this time? Yes/No

If yes, list exercises and how frequently you do them: ______________________

____

If yes, who prescribed the exercises: ______________________

What exercises or activities could you do before the work-related accident that you can no longer do because of pain or loss of function? ______________________

Do you have an attorney on this claim? Yes/No.

If yes: Name ______________________

Address ______________________

City ______________________ State_____ Zip _______