A Natural Way To Heal

Kinni Valley Chiropractic

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Name_____ **Date of Birth** _____

Patient Address _____

Male or Female (please circle one)

Home Phone _____ **Cell** _____

Date of Initial Consultation _____ **How did you hear about us?**_____

(please circle) Work Comp. Personal Injury Motor Vehicle Accident Health Insurance Cash

Date of Injury _____

Primary Insurance _____

Insurance Company Address _____

_____

Name of Insured _____ **D.O.B.**_____ **SSN**_____

Relationship to Insured: (please circle) Self Spouse Child Unknown

Policy/ID Number _____ **Claim/Group Number** _____

Adjusters Name _____ **Adjuster Phone** _____

Secondary Insurance Name _____ **Policy/ID Number** _____

Group Number _____ **Name of Insured** _____

Relationship to Insured: (please circle) Self Spouse Child Unknown

Attorney Name/Address/Phone _____

_____

_____

PATIENT CONDITION

Describe your major complaint(s): _____

_____

Date you first noticed symptoms: _____ Describe when they began: _____

_____

Have you had these symptoms before: ☐YES ☐NO If yes, when:_____

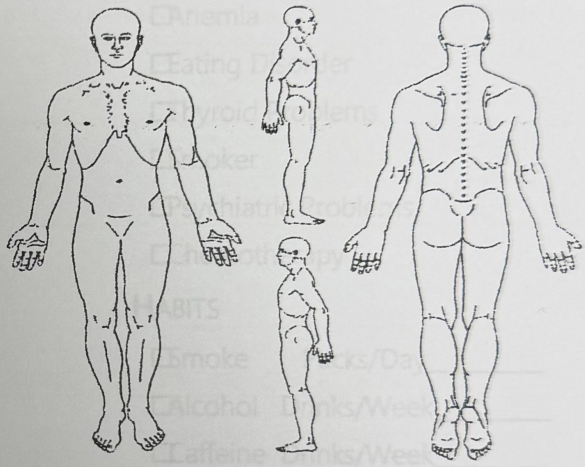
How often do you experience these symptoms?

☐Constantly (76%-100% of the day)

☐Frequently (51%-75% of the day)

☐Occasionally (26%-50% of the day)

☐Intermittently (0%-25% of the day)



How would you describe the symptoms?

☐Sharp	☐Shooting	☐Stabbing	☐ Weakness
☐Dull	☐Burning	☐Stiffness	☐Throbbing
☐Numb	☐Tingling	☐Cramps	☐Achy

How are your symptoms changing?

☐Getting Better ☐Getting Worse ☐No Change

How would you rate your symptoms at their:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

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

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you seen any other health care professionals for this condition? ☐YES ☐NO If yes, list providers:

Name Address Date

_____

_____

Have you had any test done for your symptoms? ☐YES ☐NO If yes, please check and give dates

☐X-Rays _____ ☐CT Scan_____ ☐MRI_____ ☐Lab_____ ☐Other_____

Please indicate findings if known: _____

Have you ever received chiropractic care before? ☐YES ☐NO If yes, please list:

Name Address Date

_____

_____

HEALTH HISTORY

Place a mark on the box to indicate if you have had any of the following:

☐Headaches	☐Numbness	☐Shingles
☐Migraines	☐Heart Attack	☐Hepatitis
☐Congenital Heart Defect	☐Stroke	☐Kidney Problems
☐Pacemaker	☐Alcohol/Drug Abuse	☐Cancer
☐Heart Murmur	☐Venereal Disease	☐Anemia
☐High/Low Blood Pressure	☐HIV/Aids	☐Eating Disorder
☐Difficulty Breathing	☐Diabetes	☐Thyroid Problems
☐Asthma	☐Tuberculosis	☐Smoker
☐Arthritis		☐Psychiatric Problems
☐Dizziness	☐Hepatitis	☐Chemotherapy

EXERCISE	WORK ACTIVITY	HABITS
☐None	☐Sitting	☐Smoke Packs/Day_____
☐Moderate	☐Standing	☐Alcohol Drinks/Week_____
☐Daily	☐Light Labor	☐Caffeine Drinks/Week_____

MEDICATIONS (PLEASE LIST ALL INCLUDING BIRTH CONTROLS, VITAMINS AND SUPPLEMENTS)

_____

_____

_____

GOALS FOR CARE

☐**Relief Care**- relieving the pain or discomfort

☐**Corrective Care**- Correcting the root of the problem and elimination of pain/discomfort

☐**Wellness Care**- Bringing whatever is malfunctioning in the body to its highest state of health

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that...

...Doctors of Chiropractic work with the nervous system?

...the nervous system controls all bodily functions and systems?

...Chiropractic is the largest natural healing profession in the world?

...if Chiropractic care starts at birth, you can achieve a higher level of healing throughout life?

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged direct to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor's for X-rays is for examination of X-rays only. The X-ray negative will remain in the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZE CARE SIGNATURE:	DATE:
WHO SHOULD RECEIVE BILLS FOR PAY ON YOUR ACCOUNT? ☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ WORKERS COMP. ☐ AUTO INSURANCE ☐ MEDICARE ☐ HEALTH INSURANCE	

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that we will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment to those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.