chiropractic

Bringing Out The Best In You!

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New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____
Address _____
City/State/Zip _____
Phone #s (home) _____ (cell) _____
Email address _____
SS # _____ Birthdate _____ Age _____
Occupation _____ Employer _____
Is it okay to contact you at work? ❍ no ❍ yes Work # _____
Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed
Spouse/Partner Name: _____
Phone #(s) _____
Is it okay to text you? ❍ no ❍ yes
Favorite hobbies or interests _____
Emergency contact: Name _____
Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes
If yes, please tell us who _____ Phone # _____
Were you pleased with your care? ❍ no ❍ yes
How did you find out about our office? _____
Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____
When did the incident occur? _____
Attorney (if applicable) _____ Phone # _____
Are you receiving care from other health professionals? ❍ no ❍ yes
If yes, please name them and their specialty _____
_____
Please list any drugs or medications you are taking _____
_____
Please list any vitamins/herbs/homeopathics/other you are taking _____
_____
_____
Are you pregnant? ❍ no ❍ yes If yes, what month? _____

Current Health

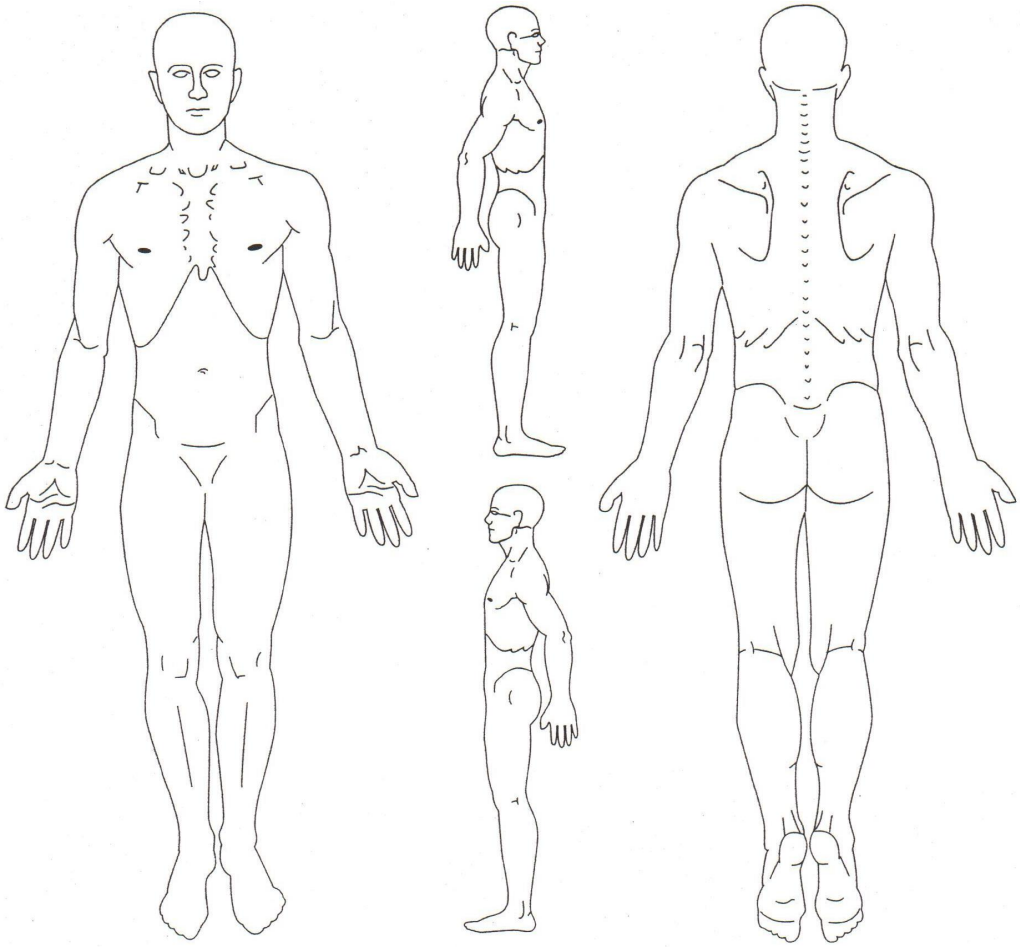
What are your pressing health concerns? _____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the pain you are experiencing. **D**=Dull **B**=Burning **N**=Numb **S**=Stabbing/Cutting **T**=Tinging/Cutting **C**=Cramping



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking

❍ bending ❍ lying down ❍ weather ❍ other

Please explain _____

_____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain _____

_____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other _____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Date of last: Physical Exam_____Spinal X-Ray_____Blood Test_____
Spinal Exam_____Chest X-Ray_____Urine Test_____
MRI, CT-Scan, Bone Scan_____

How many children do you have? _____ FEMALES: If you have children, how many have you had by vaginal delivery? _____ How many By C-Section?_____
Have you had any epidurals for delivery?_____ ☐ Yes ☐ No If Yes, how many times?_____

If Applicable – date of last menstrual period: _____

Do you drink ☐ Coffee (how many cups per day? _____) ☐ Tea (how many cups for day? _____)
☐ Alcohol (how many ounces per day?_____)

Do you use ☐ Cigarettes (how many per day?_____) ☐ Sugar (how many ounces per day?_____)
☐ Recreational Drugs? ☐ Artificial sweeteners?_____

Do you have, or have you had, any of the following (please check all that apply)?

☐ pneumonia	☐ Have Now	☐ Had in the Past	☐ depressions	☐ Have Now	☐ Had in the Past
☐ pleurisy	☐ Have Now	☐ Had in the Past	☐ arthritis	☐ Have Now	☐ Had in the Past
☐ epilepsy	☐ Have Now	☐ Had in the Past	☐ rheumatic fever	☐ Have Now	☐ Had in the Past
☐ eczema	☐ Have Now	☐ Had in the Past	☐ thyroid disease	☐ Have Now	☐ Had in thePast
☐ colitis	☐ Have Now	☐ Had in the Past	☐ whooping cough	☐ Have Now	☐ Had in the Past
☐ mumps	☐ Have Now	☐ Had in the Past	☐ heart disease	☐ Have Now	☐ Had in the Past
☐ polio	☐ Have Now	☐ Had in the Past	☐ smallpox	☐ Have Now	☐ Had in the Past
☐ cancer	☐ Have Now	☐ Had in the Past	☐ diabetes	☐ Have Now	☐ Had in the Past
☐ measles	☐ Have Now	☐ Had in the Past	☐ anemia	☐ Have Now	☐ Had in the Past
☐ stroke	☐ Have Now	☐ Had in the Past	☐ rashes	☐ Have Now	☐ Had in the Past
☐ influenza	☐ Have Now	☐ Had in the Past	☐ allergies _____	☐ Have Now	☐ Had in the Past
☐ chicken pox	☐ Have Now	☐ Had in the Past			
☐ neck pain	☐ Have Now	☐ Had in the Past	☐ low back pain	☐ Have Now	☐ Had in the Past
☐ headache	☐ Have Now	☐ Had in the Past	☐ migraines	☐ Have Now	☐ Had in the Past
☐ arm pain	☐ Have Now	☐ Had in the Past	☐ arm tingling	☐ Have Now	☐ Had in the Past
☐ shoulder pain	☐ Have Now	☐ Had in the Past	☐ hand pain/tingling	☐ Have Now	☐ Had in the Past
☐ leg pain	☐ Have Now	☐ Had in the Past	☐ leg tingling	☐ Have Now	☐ Had in the Past
☐ jaw pain	☐ Have Now	☐ Had in the Past	☐ chest pain	☐ Have Now	☐ Had in the Past
☐ lung problem	☐ Have Now	☐ Had in the Past	☐ heart problems	☐ Have Now	☐ Had in the Past
☐ ankle swelling	☐ Have Now	☐ Had in the Past	☐ blood pressure issues	☐ Have Now	☐ Had in the Past
☐ blurry vision	☐ Have Now	☐ Had in the Past	☐ irregular heartbeat	☐ Have Now	☐ Had in the Past
☐ vision probs	☐ Have Now	☐ Had in the Past	☐ cold extremities	☐ Have Now	☐ Had in the Past
☐ stuffy nose	☐ Have Now	☐ Had in the Past	☐ difficulty breathing	☐ Have Now	☐ Had in the Past
☐ fainting	☐ Have Now	☐ Had in the Past	☐ weight loss	☐ Have Now	☐ Had in the Past
☐ poor appetite	☐ Have Now	☐ Had in the Past	☐ excessive appetite	☐ Have Now	☐ Had in the Past
☐ nervousness	☐ Have Now	☐ Had in the Past	☐ confusion	☐ Have Now	☐ Had in the Past
☐ depression	☐ Have Now	☐ Had in the Past	☐ dental problems	☐ Have Now	☐ Had in the Past
☐ exces. thirst	☐ Have Now	☐ Had in the Past	☐ frequent nausea	☐ Have Now	☐ Had in the Past
☐ heartburn	☐ Have Now	☐ Had in the Past	☐ discolored urine	☐ Have Now	☐ Had in the Past
☐ irritable bowel	☐ Have Now	☐ Had in the Past	☐ black/bloody stool	☐ Have Now	☐ Had in the Past
☐ constipation	☐ Have Now	☐ Had in the Past	☐ hemorrhoids	☐ Have Now	☐ Had in the Past
☐ liver problems	☐ Have Now	☐ Had in the Past	☐ paralysis	☐ Have Now	☐ Had in the Past
☐ numbness	☐ Have Now	☐ Had in the Past	☐ fatigue	☐ Have Now	☐ Had in the Past
☐ dizziness	☐ Have Now	☐ Had in the Past	☐ loss of sleep	☐ Have Now	☐ Had in the Past
☐ hearing issue	☐ Have Now	☐ Had in the Past	☐ ear pain	☐ Have Now	☐ Had in the Past

Past injuries can affect present health – please check all that apply to you:

☐ falls/accidents	☐ Have Now	☐ Had in the Past	☐ sports injuries	☐ Have Now	☐Had in the Past
☐ auto accidents	☐ Have Now	☐ Had in the Past	☐ spinal tap	☐ Have Now	☐ Had in the Past
☐ use(d) cane	☐ Have Now	☐ Had in the Past	☐ head injuries	☐ Have Now	☐ Had in the Past
☐ broken bones	☐ Have Now	☐ Had in the Past	☐ surgery	☐ Have Now	☐ Had in the Past
☐ traction	☐ Have Now	☐ Had in the Past	☐ dislocations	☐ Have Now	☐ Had in the Past

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us _____

_____

_____

_____

_____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscribers's SS # _____ Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____ Relationship to Patient: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed as outlined.

I hereby authorize Kennedy Chiropractic/Dr. Shawn P. Neville to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to Kennedy Chiropractic/Dr. Shawn P. Neville of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to me or Kennedy Chiropractic/Dr. Shawn P. Neville based in whole or in part upon the charges made for services received. I hereby appoint Kennedy Chiropractic/Dr. Shawn P. Neville authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Kennedy Chiropractic/Dr. Shawn P. Neville.

In order to file your claims in a timely manner, we need current and accurate insurance information for you and your dependents. We will do our best to confirm eligibility and level of insurance coverage for care; however, it is ultimately YOUR responsibility to know your own insurance benefits in relation to what your insurance covers and what it does not. Should your insurance carrier determine that any or all of our services are inelgibile for payment, you will be billed directly for those services. Late payment for non-coverage, deductible and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.

Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier.

If you have any questions, ask.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Kennedy Chiropractic to treat my condition as deemed appropriate. At Kennedy Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Kennedy Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____